

**The role and use of accounting in the implementation of
New Public Management ideas in Irish hospitals**

Geraldine Robbins

**Doctor of Philosophy
University of Edinburgh
2005**



DECLARATION

I hereby certify that this thesis does not contain material which has been accepted for the award of any other degree or professional qualification in any university and that, to the best of my knowledge and belief, the thesis does not contain material previously published or written by another person, except where due reference is made in the text of the thesis.

Geraldine Robbins

27th May 2005

ABSTRACT

This study examines the use of accounting information in the management of Irish hospitals. The Irish acute hospital sector is a significant consumer of public resources, absorbing almost half of the Department of Health & Children non-capital budget. This research was motivated by the absence of detailed studies on the use of accounting information in public sector management in Ireland. The need to provide a rich account of the complex relationship between organisational context and the functioning of accounting was identified. A qualitative research approach, using the case study method, was adopted. The New Public Management literature, together with the literatures on the professions and organisational trust, offered a conceptual perspective from which to examine accounting in the acute hospital sector.

This research explores, analyses and explains the changes in accounting that have coincided with changes in management practices in four Irish hospitals, situated across two health board areas. It explores the prevalence of the New Public Management ideas and practices. It contends: that both contextual organisational factors and organisational trust influenced the adoption of the New Public Management ideas in these hospitals; that accounting control system development has lagged a rhetoric of demands for efficiency and effectiveness; that the accounting systems do not match the internal processes or structures of the organisations; that the need for information for management control has been overlooked; that accounting change has not followed increased calls for improved management of scarce resources; that each of the hospitals' budgetary systems have an outward appearance of rationality but fail to provide useful management information; that there is a secrecy and withholding of financial information from clinicians who are increasingly the focus for cost efficiencies; that each of the hospitals' accounting systems are tied to historical concerns for stewardship which permeated both the private and public sectors in the 1970's; and that whilst private sector accounting practices have developed to reflect new modes of managing, accounting practices in the two health boards and four hospitals have undergone little change.

CONTENTS

Declaration	ii
Abstract	iii
Contents	iv
List of Tables	v
List of Figures	vi
List of Abbreviations	vii
Acknowledgements	viii
Chapter 1 Introduction	1
Chapter 2 Conceptual Perspective: What is NPM?	13
Chapter 3 Conceptual Perspective: Accountability, Performance Measurement and Accounting	35
Chapter 4 The Institutional Background: NPM Implementation in Ireland	62
Chapter 5 Research Methodology	84
Chapter 6 Contextual Background on the Case Study Sites	105
Chapter 7 Ashford Regional Hospital	139
Chapter 8 Maria Theresa Hospital	181
Chapter 9 Norhop Hospital	214
Chapter 10 Southop Hospital	240
Chapter 11 An Overview of Convergences and Commonalities	267
Chapter 12 Conclusions	290
Appendices	307
Acts of the Oireachtas referred to in this Study	326
Bibliography	327

List of Tables	page
2.1 Descriptions of NPM based on the literature	18
3.1 Outline of Hood's doctrinal components of NPM and justification for them	39
3.2 Increased visibility of basic accounting techniques and practices	51
4.1 Civil service, public service and public sector definitions	63
4.2 Codification by statute of elements of NPM	76
4.3 Other legislation helping to embed NPM in the Irish Public Service	77
5.1 Key comparative characteristics of the case study hospitals	86
5.2 Case study typology	93
5.3 Alternative case study typologies	94
5.4 Interview typologies	96
6.1 Factors that have influenced the current organisation, management and financing of Irish hospitals	105
6.2 Private health insurance customers	115
6.3 Exchequer allocation to health 1997-2004	116
6.4 National Partnership Agreements	121
6.5 Acute hospital bed statistics	122
6.6 Chronological list of key reviews, reports, strategies and legislation affecting the development of acute hospital services in Ireland	123
6.7 Recent healthcare reform reports	124
6.8 Main elements of the health service reform programme	134
6.9 Health management support systems	135
7.1 Activity statistics for Ashford	144
7.2 Staffing statistics Ashford	145
7.3 Allocation of the hospital budget between pay and non-pay costs 2002	151
7.4 Model of annual budgetary process at Ashford	160
7.5 Service Planning process for 2002	161
8.1 Information on hospital activity	186
8.2 Personnel statistics for acute hospitals in the area health board	200
8.3 Non-pay expenditure at Maria Theresa relative to other acute hospitals in the area health board	201
9.1 Internal and published documents acquired from the DoH&C, area health board and hospital	216
9.2 Population of the two counties in the area health board	217
9.3 Norhop activity measures	219
9.4 Service planning and review process	221
9.5 Devolvement of service plan preparation and development of staff consultation and involvement in the service planning process	224
10.1 Staffing statistics for Southop	240
10.2 Activity statistics for Southop	241
11.1 Commonalities and divergences across the case studies	268

List of Abbreviations

A&E	Accident & Emergency
CEO	Chief Executive Officer
CIS	Clinical Indemnity Scheme
DBG	Delivering Better Government
DoH&C	Department of Health & Children
ERHA	Eastern Regional Health Authority
FISP	Financial Information Systems Project
GP	General Practitioner
HAA 1996	Health Amendment Act 1996
HEC	Hospital Executive Committee
HIPE	Hospital Inpatient Enquiry System
HOMG	Hospital Operation Management Group
HMAG	Hospital Management Advisory Group
HSEA	Health Service Employers Agency
HSE	Health Service Executive
HSNPF	Health Service National Partnership Forum
IHCA	Irish Hospital Consultants Association
IMO	Irish Medical Organisation
IMR	Integrated Management Report
JIMA	Journal of the Irish Medical Association
MDU	Medical Defence Union
MIF	Management Information Framework
MT	Maria Theresa (Hospital)
NHB	Northern Health Board
NHO	National Hospitals Office
NPFM	New Public Financial Management
NPM	New Public Management
NTPF	National Treatment Purchase Fund
OECD	Organisation for Economic Co-operation and Development
PAS	Patient Administration System
PMDS	Performance Management Development System
PMSA 1997	Public Service Management Act 1997
PPARS	Personnel, Payroll and Related Systems
SMI	Strategic Management Initiative
VFM	Value for Money
WTE	Whole Time Equivalent
The Department	The Department of Health & Children
The Board	The area health board

Irish language terms used

Taoiseach	Prime Minister
Dail	Lower House
Seanad	Upper House
Oireachtas	Parliament

Acknowledgements

I am grateful to a number of people who have supported this study. I am grateful to the staff of the hospitals, health boards and Department of Health & Children who participated in this study and without whose co-operation and involvement this study would not have been possible. I am also grateful to the chief executive officers of the two health boards who supported this study from the outset.

I am grateful for the direction and guidance offered by Professor Irvine Lapsley of the Management School at the University of Edinburgh under whose generous supervision both I and this study benefited greatly. Thanks also to Dr. Lisa Evans of the University of Edinburgh for her advice, helpful insights and encouragement. During this time I also enjoyed support from many of the other teaching and administrative staff of the Management School at the University of Edinburgh.

To the Irish Research Council for the Humanities and Social Sciences – sincere thanks for significant financial support in the form of two Government of Ireland Senior Research Scholarships which freed me to pursue this study. Thanks also to the Chartered Institute of Management Accountants for a Ph.D. grant, the ARECHAS research network for additional financial support, and to NUI Galway for financial support under its Ph.D. grant scheme for staff, its Millennium Research Fund scheme, and its special library fund scheme.

To my colleagues in the Department of Accountancy & Finance at NUI Galway – thank you for your support. A special thanks to Keith Warnock who kindly offered to read an earlier draft and to Dr. Mary Quinn for her wise counsel throughout.

Finally, to my family in Galway and Clara – thank you for your support and forbearance during this study.

CHAPTER 1

INTRODUCTION

1.1 Introduction

This study examines the use of accounting in the implementation of New Public Management (hereafter NPM) ideas in Irish hospitals. The study was motivated by the absence of detailed studies of accounting in the Irish public sector. A “watershed” in public administration was witnessed globally in the 1980’s, with governments across the developed world adopting a plethora of techniques in an attempt to improve public sector performance (Lynn, 1998:108). Debate on public sector reform increased in the early 1990’s in Ireland culminating in the Strategic Management Initiative (hereafter SMI) to introduce NPM into the public sector with the enactment of the Public Services Management Act (hereafter PSMA) 1997. Changes in public sector management in Ireland arrived later than in many other developed economies. However, when public sector reform was embraced it was codified in legislation, ensuring a legacy and persistence of NPM ideas in the Irish public sector. This study examines the introduction of NPM ideas in a specific part of that public sector – the health sector and more specifically the acute hospital sector.

New Public Management includes: a greater focus on results, increased value for money, devolution of authority, hands-on professional management, enhanced flexibility and discretion over resource use, strengthened accountability and control, a client and service focus, a shift to greater competition, explicit standards and measures of performance, and greater discipline and prudence in the use of resources (Hood, 1991; OECD, 1996). The NPM concept is built on the “language of managerial and economic rhetoric from the private sector” (Pettersen, 1999:378). It assumed a dominant role in global reforms of the public sector in the 1980’s and 1990’s. The term NPM “was coined because some generic label seemed to be needed for a general, though certainly not universal shift, in public management styles” (Hood, 1995b:94). It is not only a way of reorganising the management of public sector bodies, but also of reorganising the

reporting and accounting approaches to bring them closer to private sector commercial business methods (Dunleavy & Hood, 1994). Across the reform movement there is clear use of managerial knowledge and mechanisms such as customer service, performance-based contracting, competition, market incentives and deregulation. In different contexts the impetus driving NPM reforms varied. Public sector management and organisation cannot be separated from its social and political context (Hood, 1974; Kickert, 1997). Hence the need to consider the NPM reform context.

1.2 The Reform Context

The importance of context to the study of NPM reforms is critical given that “the indiscriminate export of hand-me-down public management may stifle appropriate variety in public sector policy response” (Hood, 1995a:169). NPM does not simply involve the importation of an NPM tool-kit for successful implementation of reforms. Pollitt (2003) argues that the success or failure of public sector reform depends to a large extent on the functional and contextual knowledge available at the implementation of reforms. He argues that “a technique or organisational structure which succeeds in one place may fail in another” (Pollitt, 2003:122). Therefore an understanding of the social and organisational context is also important. This study examines the changes in public sector management in the overall Irish public sector (chapter 4) before examining NPM in the acute public hospital sector. Changes in public sector management in the hospital sector will be influenced by changes in the wider health sector. Likewise changes in management in the health sector will be influenced by changes in public sector management in the wider Irish public sector. Previous global studies of NPM have not included an Irish dimension (Olson, Guthrie, & Humphrey, 1998; Pollitt & Bouckaert, 2000). However, there are many of the dimensions of NPM evident in the Irish public sector.

Governmental institutional structures and practices remained predominantly the same from the foundation of the state in 1922 until the passing of the PSMA 1997. As elsewhere the focus of the public sector from its inception was on probity, compliance,

procedural justice and equity of treatment in public sector dealings. The Irish public sector reform story is one of reluctance over many years to modify public service management as recommended by both government-commissioned reviews and White Papers (Brennan Commission, 1935; Devlin, 1969; Irish Government, 1985). There is evidence of NPM in some of these documents (which will be outlined in chapter 4). However, significant change in public sector management did not occur until the launch of SMI in Ireland in 1994. The fundamental focus of SMI was the desire for an excellent service for government and for the public as customers and clients at all levels (Coordinating Group of Government Secretaries, 1996). By the mid-1990's, there was support for a change in public administration from both the political and administrative stakeholders. Since then, the Irish civil and public service has undergone a process of modernization. The introduction of NPM must be understood in the context of socio-economic and political forces (Pollitt & Bouckaert, 2000). NPM in Ireland has primarily been through implementation of the SMI but it has also been embedded through the concept of partnership at national and organizational level (Doyle, 2000). The reform agenda of the 1990's brought with it legislative, policy and management reforms. Sectoral legislation in health – the Health (Amendment) Act (hereafter HAA) 1996 - introduced NPM ideas into this sector. Accountability and performance measurement terminology was to permeate the hospital sector over the next eight years. This study examines the role and use of accounting that coincided with the implementation of NPM ideas in four Irish hospitals.

1.3 The Need for Contextual Studies of Accounting

There are various approaches that could be used to study accounting in organisations and for each of these approaches there is support and criticism. Otley (2001:246) argues that it is important to develop management accounting research which “connects with real organizations and their practices”. He favours intensive, field-based research methods “to investigate the wide variety of control mechanisms deployed by organisations in practice which can then be used to generate theory inductively” (Otley, 2001:256). This is the approach favoured and adopted in this study. Case studies

involving an examination of the use of accounting in implementing NPM ideas in four Irish hospitals were developed.

Those who favour the more deductive approaches may do so for practical reasons, for instance, to avoid problems of gaining access which must be negotiated and maintained during intensive field research such as case study research, and also to ease the burden of analysis in the latter stages of the project as the larger part of deductive research work is front ended (Otley, 2001). In interpretative accounting research the interaction of accounting practices with other social practices in the organisation is examined to better understand not only the nature but also the role and use of accounting. The theoretical orientation of this research may be described as a contextual interpretivist inductive approach.

The case for qualitative research has been advanced by many in the management and accounting literature (Morgan & Smircich, 1980; Hopwood, 1983; Tomkins & Groves, 1983; Roberts & Scapens, 1985; Lapsley, 1988; Hopwood, Page, & Turley, 1990; Humphrey & Scapens, 1996; Lapsley, 1997; Jonsson, 1998). In recognition of the fact that the role of accounting and other controls cannot be fully understood in isolation (Hopper & Powell, 1985), this study undertook to locate the examination of NPM reforms in Irish hospitals, and the role of accounting in facilitating those reforms, in its organisational context. Kaplan (1986) suggests that the current lack of theories in management accounting can be attributed to a failure to observe how management accounting work functions in organizations. In the accounting literature over the years there have been repeated calls to study accounting in its organisational context (Hopwood, 1983; Kaplan, 1986; Hopwood, 1987; Hopwood, 1990; Miller, 1994; Ahrens & Dent, 1998; Hopwood, 1999; Nyland & Pettersen, 2004).

This study accepts these views of accounting advanced in the literature and the importance of examining the wider organisational setting in which accounting is located. Historical antecedents that have shaped the development of the practice of accounting in

organisations must be studied to fully understand the current role and use of accounting in organisations.

1.4 Research Objectives

The objective of this research is to document, analyse and explain the changes in accounting that have coincided with changes in management practices in four Irish hospitals. This overriding objective can be subdivided into component parts:

- 1) How or to what extent is NPM evident in Irish hospitals?
- 2) How are NPM ideas being implemented in Irish hospitals?
- 3) How are accounting techniques being used to support the introduction of NPM ideas in these hospitals?

1.5 Conceptual Perspective

The conceptual perspectives offered by three literatures (NPM, the professions and organisational trust) offer insights into understanding the emergence and penetration of NPM ideas in the Irish public sector. Power (1994) notes that the growth of NPM has seen public accountability redefined by concepts such as goal definition, efficient allocation of resources, and financial performance. Ezzamel & Willmott (1993) and Lapsley (1999) have noted an increasing emphasis on financial accountability as part of the reforms, whilst (Pettersen, 2001:561) notes that accounting information is a “key ingredient in the managerial decision-making processes in organisations”. In many countries accounting has been central to the implementation of change programmes across the public sector (Guthrie & Humphrey, 1996; Guthrie, Olson, & Humphrey, 1997; Olson et al., 1998; Guthrie, Olson, & Humphrey, 1999; Hopper, Otley, & Scapens, 2001; Newberry & Barnett, 2001). Reforms in the public sector in some countries, for example Sweden, have changed the approach to managing, controlling, and accounting for public services such as health and education (Brunsson & Olsen, 1997; Brunsson & Sahlin-Andersson, 2000:722). In the UK Lapsley (2001a:349) concluded that “accounting has become accepted as an essential ingredient of all modernising reforms in UK healthcare policy”, whilst Pallot (2003) notes how in New

Zealand changes have taken place not only in public sector management styles and techniques but also in accounting.

This focus of this study is on whether or not accounting supported and facilitated the introduction of NPM ideas into the Irish public hospital sector. When the existing NPM literature could not offer insights into the data gathered during the study, other literatures (trust, professions, and religious) were also drawn upon to explain the observations made. This concurs with Humphrey & Scapens (1996:91) who argue that “relying solely on the content of a pre-selected theory, necessarily forces the researcher to work out from the theory, leaving it unchallenged and resulting in a failure to develop a theoretical framework focused explicitly on the issues and questions raised by the case”.

It has been recognised that the implementation of performance measurement systems has reduced the professional autonomy of groups across a wide number of public sector institutions (Hoggett, 1996). Doctors are compelled to work in large specialised organisations funded by public monies where there is an increasing focus on efficiencies. It is this increasing value of organisational efficiency, a key objective of NPM reforms, which directly impinges on the standing of the professions relative to other organisational groups. There is evidence in previous studies of an enduring and persistent conflict between managers and clinicians when the autonomy of clinicians to work independently is threatened by administrative values which are not consistent with those of the professional (Wilensky, 1964; Freidson, 1970, 1975; Abernethy & Stoelwinder, 1991; Jones & Dewing, 1997; Kurunmaki, 1999). Conflict is likely to arise in organisations staffed by groups which have a “high professional orientation” and who are controlled by output forms of control, where performance is measured against imposed targets (Abernethy & Stoelwinder, 1995:13). The introduction of NPM reform in public acute hospitals is an attempt to increasingly control the work of occupational groups in the hospitals, among them consultant hospital doctors.

Rising calls for greater evaluation of the performance of others is seen by some as a creeping distrust spreading through the public sector (Hoggett, 1996; Miller, 1996). It is recognised that accounting is not an impartial technique (Miller, 1996) and that accounting systems and know-how are part of the structure and use of power in organisations and society (Baxter & Chua, 2003). An awareness and consideration of these issues in using accounting to support the penetration of NPM implementation is necessary. The introduction of NPM reforms has led and continues to lead to a focus on managerial issues. The expansion of the performance measurement process (to discharge accountability) is not neutral and is likely to meet with resistance in bureaucratic organisations employing groups with strong professional orientations. This prior literature is drawn upon in this study when examining the manner in which NPM ideas have been implemented in Irish hospitals.

Concerns regarding trust need to be considered in the implementation of NPM ideas and practices in large specialised public sector organisations. This feature of NPM reforms has not been adequately considered in studies to date, although Hood (1995a:174) did consider that what is being observed in NPM implementation could be understood as a “a shift from a high-trust to low-trust” series of relationships in the public sector. Hood (1995b:97) argues that “accountability involves more active control of public organisations by visible top managers wielding discretionary power”. This increased discretionary power is one of the facets of NPM that distinguishes it from old style public administration where the emphasis was on hands-off management by relatively anonymous public servants.

The introduction of NPM in Irish hospitals considers these aspects of the organisational life of acute public sector hospitals, which are becoming increasingly specialised and complex organisations. Consideration of the concerns of professional groups who staff these hospitals, together with the level of systems support at implementation, will influence the level of embeddedness possible for NPM ideas in hospitals.

1.6 Research Methodology

A qualitative contextual approach was adopted to address this study's research objective, and the case study method was selected to examine accounting in its organisational context – in the implementation of NPM ideas into the acute hospital sector in Ireland. Lapsley (1988:28) supports the use of case study research to enrich data collection in order to examine internal accounting and management information systems, thereby allowing us to deepen our understanding of “what actually happens in organisations”. Recognising that accounting and other controls influence the management of organisational performance, this call for the study of accounting in its organisational setting has been subsequently supported (Otley, 1990; Scapens, 1990; Otley & Berry, 1994).

Four comparative case studies were used to address the research objective and the three research questions outlined above (section 1.4). The comparative case study approach examines multiple situations within an overall framework. The case study method provides an opportunity to examine context-specific factors that impact on organizational change situations. The success or failure of public management reform is heavily context specific (Pollitt, 2003). Pollitt (2003:122) argues that there is no certainty that “a technique or organisational structure” which is successful in one place will produce similar positive results in another context. Any empirical research method needs to capture this complexity and context specificity. For this reason the case study method was adopted.

This study recognises that there is no such thing as a truly ‘correct’ case study (Humphrey & Scapens, 1996:97), only a case study that seeks to develop a holistic appreciation of the issue under consideration (Llewellyn, 1992:29). In the endeavour to ensure that the case studies were as complete as possible, a triangulation approach to data gathering was used. Triangulation involves “the combination of multiple methodological practices, empirical materials, perspectives. ... In a single case study it is best understood as a strategy that adds rigor, breadth, complexity, richness, and depth

to any inquiry” (Flick, 2002:231). Given that objective reality can never be captured, triangulation is an attempt to secure an in-depth understanding of the phenomenon the researcher is trying to understand (Denzin & Lincoln, 2000:5). This study is interpretational in that it seeks to examine and interpret the accounting control system and relate it to its environment and to the NPM literature. Qualitative findings grow out of three kinds of data collection: interviews, direct observation and written documents (Patton, 2002). Accepting this, three kinds of qualitative data were used in this study in an attempt to add rigour, depth and richness to this work: semi-structured interviews, some limited observation and both published and unpublished DoH&C, health board and hospital documents. After cases are built individually they are analyzed comparatively with the objective of seeking out common experiences, patterns, variables and relationships as recommended by Agranoff & Radin (1991) and Yin (1994). Commonalities, patterns and divergences between the cases are discussed in chapter 11. This study of the use of accounting to support the introduction of NPM in Irish hospitals involves a sample of four hospitals and is therefore not definitive. The strengths and weaknesses of the qualitative research approach and the case study method adopted to address the research questions in this study are provided in chapter 5.

An examination of the literature on NPM suggested a reoccurrence of a number of themes. These were used to develop a skeletal conceptual framework, from which variables were identified and subsequently drawn on as prompts during the semi-structured interviews. However, interview questions were not limited to these themes. All semi-structured interviews lasted between one and two hours. Tables A1 to A7 in Appendix A contain details of all fifty-seven interviews with fifty-four staff in the four hospitals, in the two health boards and in the DoH&C.¹

1.7 Structure of the Thesis

The research commences with an examination the nature of NPM (chapter 2). The special characteristics of the public sector are examined. Descriptions of NPM are

¹ Three individuals were interviewed twice.

provided and the consensus on the managerial nature of NPM reforms is considered. A variety of drivers of NPM reforms have been witnessed globally. These drivers and this global dimension of NPM (Yeatman, 1994; Aucoin, 1996; Borins, 1997; Kettl, 1997; Kickert, 1997; Kaboolian, 1998; Olson et al., 1998; Guthrie et al., 1999; Bardouille, 2000; Pollitt & Bouckaert, 2000; Torres & Pina, 2002) are explored to identify the different ways in which NPM reforms emerged. Criticisms and difficulties in implementing NPM reforms are also examined in chapter 2.

Recognising that accountability and performance measurement are key elements of NPM, these concepts are explored in chapter 3 as is the role of accounting in facilitating performance measurement and in discharging accountability. The discussion considers the changing nature of accountability with its increasing emphasis on managerial accountability at the expense of eroding other forms of accountability heretofore associated with a public service ethos – constitutional, democratic and public accountability. The expansion of the role and nature of performance measurement is then considered as is its impact on the dominant professional group in hospitals – consultant hospital doctors. Concerns with organisational trust coinciding with the implementation of NPM reforms and greater demands for accountability are also considered in chapter 3.

As noted earlier, the organisational context of reforms influences their implementation. In order to appreciate the arrival of NPM in the acute hospital sector via an examination of four hospitals, the background to the slow and reluctant emergence of NPM in Ireland is examined in chapter 4. Despite reviews and examinations of the workings of the public sector, the first in 1932, little reform took place even in instances where reports were welcomed and accepted by government. The ability and will to implement reforms was lacking. This changed with the launch of the SMI in 1994. Chapter 4 concludes with an outline of the nature of the key reforms introduced since then as a background for appreciation of reforms attempts in the hospital sector.

The research approach adopted, and the research methodology and techniques employed in the research, are outlined in chapter 5. The research objective together with the three research questions developed to address this objective are clearly stated. This is followed in chapter 6 by an outline of the contextual factors that have influenced and shaped current acute public hospital service provision in Ireland. Religious organisations played a substantial role in shaping the landscape of acute public hospital services. Their role and that of the Catholic Church which was a substantial influence on health policy is examined. The emergence of NPM in the Irish health sector primarily via codification of NPM ideas in the HAA 1996 is reviewed in chapter 6. This is followed by the four case studies in chapters 7-10: Ashford Regional Hospital (chapter 7), Maria Theresa Hospital (chapter 8), Norhop Hospital (chapter 9), and Southop Hospital (chapter 10). Following the development of the four case studies, commonalities and divergences between the cases are extracted in chapter 11. The significance of these commonalities and divergences and their confirmation (or otherwise) of issues raised in the developing NPM literature is considered in an attempt to develop and enhance that literature and our understanding of the difficulties surrounding implementation of NPM ideas. However, no attempt is made to generalise from the findings of these four case studies, rather attempts are made to link back and develop points in the literature. The study concludes with a discussion of the implications for the NPM literature of the issues raised in the four case studies.

1.8 Contribution of this Study

This study makes two contributions. Firstly it is empirical. The study has been carried out in response to increased calls for empirical studies of accounting (see section 1.3) to deepen our understanding of the nature and role of accounting. This study addresses this gap in the literature. Secondly it contributes to a greater understanding of how hospitals are managed and how accounting information informs the management process. Hood (1995b:96) argues that “changes in public sector management are coupled with a greater use of financial data”. In other countries accounting has been fundamental to the implementation of NPM reforms (Guthrie et al., 1997). The importance of accounting is

supported by Pettersen (2001:561) who notes that accounting information is a primary component of organisational “managerial decision-making processes”. Whilst the implementation of NPM in other public sector contexts was supported by a greater use of accounting, there is a dearth of studies examining the role of accounting in the Irish public sector reform context. This study addresses this gap in developing an understanding of the role of accounting in implementing NPM reforms, specifically in the Irish public sector hospital context. It highlights the frailties and fragility of the accounting information systems in these four Irish hospitals. The study brings to light impediments to successful implementation of NPM ideas into this part of the Irish public sector. The study considers the particular difficulties of implementing NPM ideas in four public sector organisations staffed by professional groups who enjoy a large degree of autonomy over their work. It highlights the challenges facing management charged with embedding NPM in acute hospitals and in the final chapter (chapter 12) it offers insights to aid successful implementation. In this way it contributes to the developing literature on NPM.

CHAPTER 2

CONCEPTUAL PERSPECTIVE: WHAT IS NPM?

2.1 Introduction

Public administration in many parts of the world is undergoing change, reflecting the mounting expectations of citizens, the increasing complexity of governing, the growth of new technologies and the influence of debate internationally on best practice in public sector management Hood (1991; 1995b). Decentralised management environments are taking the place of centralised structures, and there is intense focus on results in countries implementing public sector management reforms (Hood, 1991, 1995b). The label “New Public Management” (NPM) has been used to encapsulate these types of changes in public management policy and practices. There is a growing literature addressing the changes in public administration and public management worldwide.

The conceptual material on NPM which informs this research is explored in this and the following chapter. In this chapter, the distinctiveness of the public sector (section 2.2), the components of NPM (section 2.3), the drivers of NPM (section 2.4), the global aspect of NPM (section 2.5), and the criticisms of NPM and difficulties in implementing reforms (section 2.6) are examined. The increased focus on the control aspect of the work of public sector managers is explored in chapter 3, together with accountability and performance measurement issues. The role of accounting in implementing NPM ideas and in facilitating control is also examined in chapter 3.

The NPM literature was used to inform this research. However, it became clear during the collection of the data that there are areas of the NPM literature that are underdeveloped – in particular, consideration of trust and the role of the professions in public sector organisations. It is impossible to refer to the public sector without referring to the professions. In public sector organisations, such as hospitals, there are many professional groups. Successful implementation of NPM ideas must consider the impact of new management practices on these groups. These key dimensions of NPM in

the existing literature are expanded and developed further in this study. This research contributes to the NPM literature by providing a more complete account of the difficulties surrounding implementation of NPM ideas, specifically in four case study hospitals. NPM is not just about a move to more flexible management employing additional management techniques. It requires an understanding of the impact of proposed changes on the professions working in public sector organisations. It also requires consideration of the existence or non-existence of organisational trust in these public sector organisations. These extensions or refinements to the NPM literature are explored in the next chapter. Before that the essence and substance of NPM are examined, beginning with a review of the features of the public sector which distinguish it from the private sector.

2.2 The Public Sector

The public sector is composed of those public organisations which provide utilities and services to the community and which traditionally have been essential to the fabric of society. One of the ways the public sector differs is in how it is funded. Many (but not all) public sector organisations are funded by grants provided by government from taxes received from commercial organisations and citizens. Hofstede (1981) noted that an increasing part of national resources are spent on not-for-profit-activities and that management control in the not-for-profit sector cannot be achieved by simple extrapolation from profit-oriented and production activities. Public sector management is distinctive from that of the private sector because the characteristics of the public sector differ from those of the private sector (Hofstede, 1981; Wanna, O Faircheallaigh, & Weller, 1992; Ferlie, Ashburner, Fitzgerald, & Pettigrew, 1996). Hood (1974:474) argues that “public administration as a whole obviously suffers from special handicaps, such as legal frameworks which create time-lags, opportunities for wastage, the sheer scale of operations, and the exceptional confusion of demands”. The public sector is characterised as having: ambiguous goals and objectives, non-measurable outputs, multiple constituencies as customers, and extended decision-making processes. These

characteristics make it difficult to develop effective management control systems (Hofstede, 1981; Wanna et al., 1992; Miller, 1996; Ferris & Graddy, 1997).

Also, in the public sector, 'control' might have wider connotations, first because there are multiple diverse principals, and second because there is much less agreement about what the public sector should be doing (Smith, 1995). In addition to the differing characteristics of the public sector, there are principles inherent in the ethic of public service which distinguish it from the private sector. These include selflessness, integrity, objectivity, accountability, openness, honesty and leadership (Nolan Committee, 1995). However, management in either a private or public sector context is about the optimal commitment of resources to achieve desired results. Boston, Martin, Pallot and Walsh (1996) argue that results in this sense means the creation of things of value. What makes the public sector distinctive is that these values differ from those in the private sector, in large part because the public sector must service multiple constituencies (Boston et al., 1996).

Ferlie et al. (1996:196) argue that public sector organisations have certain characteristics that distinguish them from private sector ones, and that while the management of these public service organisations have adopted some of the characteristics and culture of private sector organisations, they remain essentially public. Public services have a "rescue function", requiring services to be provided to citizens in lower income groups who cannot pay (Ferlie et al., 1996:196). This is an important consideration in any study of public hospitals, and will be examined in the case study chapters (see chapters 7-10).

There is growing recognition that while bureaucratic institutions of the industrial era served their earlier purposes well, "increasingly they fail us" (Osborne & Gaebler, 1992:15). Prior to the introduction of NPM ideas and practices, the public sector had been managed by means of public administration. Government institutions that developed during this time were characterised by their "sluggish centralised

bureaucracies, their preoccupation with rules and regulations and their hierarchical chains of command” (Osborne & Gaebler, 1992:11-12).

The ideas of progressive-era public administration were founded on two primary doctrines: the first was “the idealization of career public service professionals” who were somewhat removed from the labour market, whilst the second doctrine held that “a battery of generalised rules should limit the discretionary powers of public servants in the conduct of business” particularly at the juncture where these career public servants met the dishonest world outside, in areas such as recruiting staff, handling money, and signing contracts (Hood, 1995a:167-168). By the mid-1990’s these doctrines were fading. In the classical public administration theory’s definition of effective government are concepts such as: “hierarchical control, specialisation, efficiency, reduced duplication and clearly defined rules and procedures” (Kamensky, 1996:250). The descriptions, definitions and explanations of NPM that follow argue for the complete opposite – less insulation of public servants from the private sector and greater managerial discretion in dealing with both human and financial resources.

2.3 What is NPM?

We do not know. The search for a precise definition has fuelled debate since the early 1980’s. Indeed, this thesis seeks to contribute to that discussion. Stark (2002:137) observes that neither its supporters nor its critics can quite grasp what the NPM is, and in particular “what is new about it – let alone on whether, taken as a whole, it is a good thing”. However he concedes that “NPM is new... but it is not radical” (Stark, 2002:149). He regards debates over NPM as part of a broader discourse over democratic governance – one that is continually “adjusting the balances and nuances of the entire set of roles available to government and to the public” (Stark, 2002:149). Barzelay and Armajani (1992) suggest that NPM is simply a continuation of past efforts to reform the public service started at the end of the last century in the UK and continued in the US. NPM emphasises “importing the best practices from private life into government” (Hood & Jackson, 1994:472). It involves not only changes in the management of public sector

bodies, but also restructuring the accounting and management reporting support function to facilitate improved management (Dunleavy & Hood, 1994). Yeatman (1994:287) argues “that the term public management suggests that the work of the public sector has more to do with the creative and pro-active agency of management than it has to do with the technical routines of administering rule”. Van Wart & Berman (1999:343) use the term NPM to mean all of the key changes emerging in public management practices, “no matter whether from total quality management, public choice, or excellence in government”. It is the managerial aspect of NPM that dominates the NPM literature and will be examined in section 2.3.1.

One interpretation of NPM is that it is a second wave of radical reform (Barzelay & Armajani, 1992). The first wave endeavoured to professionalize the public service. It paralleled the expansion of the factory as the new form of production, which facilitated mass production supported by scientific management practices. The second wave paralleled the customised production focus. Barzelay & Armajani (1992) argue that ideas of quality management in the business world influenced this second most recent wave of reform in the public sector. But quality is just one dimension of NPM. Across the reform movement there is clear use of managerial knowledge and mechanisms such as customer service, performance-based contracting, competition, market incentives and deregulation. However, whilst in some countries, such as Sweden, reforms in the public sector have attempted to change the forms of managing, controlling, and accounting for the production and delivery of services such as health and education, they have made little impact on the services themselves (Brunsson & Olsen, 1997; Brunsson & Sahlin-Andersson, 2000:722). Brunsson & Sahlin-Andersson (2000) see this increased management and control focus as an attempt to alter the public sector by turning public services into organizations, with the resulting development of organizational features such as identity, hierarchy, and rationality. The focus is then increasingly on the management and control aspect of these organisations, rather than on the public services themselves.

Whilst there is no single accepted explanation or interpretation of why NPM came about when it did, there are quite a lot of similarities in the accounts of what NPM involves: a shift in emphasis; a response to increased complexity, uncertainty and expectations; a structural and managerial dimension; key doctrinal components; and the increasing use of an array of private sector management techniques (see Table 2.1).

Table 2.1: Descriptions of NPM based on the literature

Description	Involves
Waves of reform	Second wave of reform (Barzelay & Armajani, 1992; Yeatman, 1994).
Response	To increased social and cultural complexity, uncertainty, and expectations of government (Yeatman, 1994; Wright, 1996).
Emphases	A shift in emphasis (Hood, 1995b; Thompson, 1997) to a customer driven and service oriented public sector (Barzelay & Armajani, 1992).
Dimensions	Structural dimension: disaggregated organisation, and a managerial dimension: visible management, private sector styles of management, stricter cost control, explicit measurement/quantification, greater accountability, and an emphasis on output controls rather than process (Hoggett, 1996; Thompson, 1997; Doig & Wilson, 1998; Lapsley, 1999; Denhardt & Vinzant Denhardt, 2000).
Doctrinal components	Hands-on professional management, explicit standards and measures of performance, greater emphasis on output controls, disaggregation, greater competition, stress on private sector styles of management practice, and stress on greater discipline in resource use (Hood, 1991:4-5).
Techniques	Cost improvement programmes, performance indicators, financial management information systems, financial targets and delegated budgets (Boston et al., 1996; Ferlie et al., 1996; Pettersen, 1999).
Impact	Greater impact on front line delivery units (Hood, 1991).

A notable outcome of NPM reforms – unlike many other reforms – is that they tend to survive even when political power changes hands. In Britain the Labour Party embraced most of the Conservatives’ public administration reforms. In New Zealand, when the National Party defeated the Labour Party in 1990, public administration reforms continued (Osborne, 2000). In Ireland public sectors reforms not only endured but had a

momentum once NPM ideas were codified in legislation (see chapter 4). In this way NPM reforms are robust. They have taken tenacious hold on public sector organisations and are unlikely to fade easily.

2.3.1 Consensus: Managerialism

There is quite a degree of consensus in the definition and descriptions of NPM in Table 2.1. Many of its elements have a ***strong managerial dimension***: hands-on professional management, freedom to manage, explicit standards and measures of performance, greater emphasis on output controls, disaggregation of units, greater competition, emphasis on private-sector styles of management practice and emphasis on greater discipline in resource use (Hood, 1991; Hood & Jackson, 1994). NPM aims to “release the resourceful energies of managers previously hampered by bureaucratic iron” (Hood & Jackson, 1994:472). Hood (1995b:95) describes NPM as:

a shift in emphasis from policy making to management skills, from a stress on process accountability to accountability in terms of results, from orderly hierarchies to a more competitive basis for providing public services, from fixed to variable pay, and from a uniform and inclusive public service to a variant structure with more emphasis on contract provision.

In this way NPM has had more of an impact on front line delivery units than on departments managing and controlling these (Hood, 1991).

A number of the authors referred to in Table 2.1 agree that there is both a structural and managerial dimension to implementing NPM ideas. The structural dimension involves the disaggregation of organisations with the objective of getting them to run better. The managerial dimension involves the arrival of a new management focus and increased use of techniques heretofore more associated with the private sector: more visible management, stricter cost control, explicit measurement, a stress on quantification, greater accountability, and an increased emphasis on output controls rather than on process (Hood, 1991, 1995a; Hoggett, 1996; Thompson, 1997; Doig & Wilson, 1998; Lapsley, 1999; Denhardt & Vinzant Denhardt, 2000; Pollitt & Bouckaert, 2000). One difficulty in bringing about changes in the structures and management of public sector

organisations is that there is frequently some divergence between the corporate message and internal systems and culture (Maddock & Morgan, 1998).

An increasing emphasis on the managerial element is at the core of NPM. Kettl (1997:447) regards managerialism as the influential idea behind the range of reforms that swept many democracies in the 1980's and 1990's. It arose from the recognition that traditional bureaucratic hierarchy had become unresponsive (Kettl, 1997). Reformers sought to replace parts of the bureaucratic structure with something new: "authority and rigidity with flexibility, preoccupation with structure with improvements to the process, and the comfortable stability of government agencies and budgets with market-style competition" (Kettl, 1997:447). Yet, the focus for new public managers is not only on economy and efficiency but on defining these in terms of customer satisfaction (Thompson, 1997). This connects with Barzelay and Armajani's (1992) idea (discussed in section 2.3) of the private sector's increased customised production focus as providing an impetus for management reforms in the public sector.

Osborne (2000) views the NPM debate as one about a public sector focused intensely on results and performance and less bound by rules and procedures. He sees NPM as being about an environment in which "managers can manage, innovators can innovate, and success may bring rewards" (Osborne, 2000:35). Hood (1994:619) regards the development of a 'management' terminology as a reaction against the traditional public law/political science view of public administration, with its overwhelming emphasis on public accountability issues. As a result of this stress on managerialism, a multitude of NPM techniques have emerged in the public sector: "cost-improvement programmes, performance indicators, financial management information systems, financial targets and delegated budgets" (Pettersen, 1999:377). There is an emphasis on doing more with less, on securing value for money, on the use of comparative performance indicators and on the development of enhanced cost, information and audit systems (Hood, 1991, 1995b; Ferlie et al., 1996; Hoggett, 1996; Pettersen, 1999; Bardouille, 2000; Pollitt & Bouckaert, 2000). This performance management aspect of NPM and the role of accounting in facilitating performance management are discussed in chapter 3.

In summary, Denhardt & Vinzant Denhardt (2000:550) describe NPM as a “profound shift in the way we think about the role of public administrators and how and why we do what we do”. NPM is more than a synthesis of the dimensions, emphases, and collection of techniques outlined in Table 2.1. It does not simply involve the importation of an NPM tool-kit for successful implementation of reforms. Pollitt (2003) argues that the success or failure of public sector reform depends to a large extent on the functional and contextual knowledge available at the implementation of reforms. Therefore an understanding of the social and organisational context is also important. The Irish NPM context is discussed in chapter 4, whilst the Irish historical, economic, religious and institutional context of acute hospitals is outlined and reviewed in chapter 6. Whilst an understanding of local Irish context is important in this study, it is also clear that NPM has transcended national boundaries. It is a global phenomenon (Olson et al., 1998; Pollitt & Bouckaert, 2000; Torres & Pina, 2002). The antecedents and drivers of NPM have been identified in the NPM literature and are discussed below.

2.4 The Drivers of NPM

Yeatman (1994:289) views NPM as a response to three connected contemporary facts: increased social and cultural complexity, increased uncertainty, and increased democratic expectations of government. Management reform has also been encouraged by growing demands for moderation in public-sector spending, and increasing scepticism regarding the awareness of government about the concerns of citizens (Aucoin, 1995; Boston et al., 1996; Torres & Pina, 2002). Changes in income levels and distribution, changing demographics and technologies, and rising public expectations also advanced the global spread of NPM type reforms (Hood, 1991; Kamensky, 1996). Yet there are a number of other factors which contributed to the development of NPM. Among them are the changes in basic values over time (Painter, 1990; Hood, 1995a; Painter, 1998), increasing globalisation pressures (Yeatman, 1994; Aucoin, 1995; Boston et al., 1996; Bardouille, 2000), the growth of particular political ideologies

(Pallot, 2003) and institutional pressures from organisations such as the World Bank. Each of these influences is discussed below.

Painter (1990:77) argues that “changes in basic values and their definitions are what really drive administrative reform”. He contends that administrative practices, the objects of reform, are depicted as obsolete, “not because it can with any certainty be said that the ‘science’ or practice of public administration has become more ‘advanced’ but because these practices stand in the way of the achievement of the values that currently are considered the most important” (Painter, 1990:77). Painter adopts a pessimistic view of administrative reform. He considers that the image of rejuvenation and decay, rather than the term ‘developmental’, best describes the historical pattern of public sector reform, and that values not emphasised in the current round of reforms will be reasserted at a later date (Painter, 1990). A criticism of the ‘traditional public administration’ by managerial reformers was that it encouraged the prioritising of formal over substantive concerns, the result being a loss of voice in the resulting bureaucracy for citizens demanding legitimate policy change (Painter, 1998). Hood (1995a) concurs with Painter’s view on the evolving nature of public management reform. He argues that in time the negative features of today’s public sector management will most likely be used to “make the positive aspects of its currently unfashionable alternative seem attractive” (Hood, 1995a:180). Hood (1995a:180) observes how “most ideas in public administration have an earlier life and times” and that the recurrence of these ideas in public administration is a significant feature of its ‘intellectual dynamic’. A further driver of NPM reforms was a concern by governments about a response to the threats posed by globalisation of economies.

Osborne and Gaebler (1992) argue that the effort to reform government in many countries in the early 1980s was an attempt to reposition economies to cope with global competition. A growing interest in public accountability and a belief that governments would respond was witnessed globally (Yeatman, 1994). Globalisation is used to refer to “the processes by which particular societies are coming to be incorporated into a single

world society” (Hood, 1995a:168). Bardouille (2000:82) contends that NPM plays a valuable role as a policy tool and a means by which to “advance a rhetoric of efficiency, prudence and efficacy in state management at a time when there is mass liberalisation of national economies”. She argues that “increasing economic interdependence and the convergence of ideological values and policy prescriptions amongst OECD countries have become the ideal breeding ground for the techniques and doctrines of what has been termed the NPM” (Bardouille, 2000:84). Bardouille concludes that globalisation has been the principal catalyst for the proliferation of NPM concepts and practices, but so too have evolving political ideologies. These differ across countries and influence the manner in which NPM is adopted.

For example, in New Zealand there may be a particular political ideology underlying the expansion of NPM ideas, with the NPM model being more than simply a way of improving management in the public sector (Pallot, 2003). Pallot argues that the most significant thing about NPM in New Zealand is the way in which “it renders the public system more private” (Pallot, 2003:134). She suggests that changes that have taken place in public sector management styles and techniques, including accounting, have shielded the sector from public scrutiny and discussion. Pallot believes that “the New Zealand Treasury acted as an advocate of the ‘new right’ economic liberalisation agenda being played out globally and that at times it was a voice for large business interests who saw opportunities for themselves in privatising the New Zealand public sector” (Pallot, 2003:134).

Pallot positions the tension between the Executive Government (with the Treasury as advocate) and Parliament (with The Audit Office as advocate) as part of a wider conflict between a ‘privatisation’ agenda and a ‘democratisation’ agenda in New Zealand (Pallot, 2003:134). The concern of the Treasury in New Zealand, or the Department of Finance in the Irish context, is with managerial accountability and a quest for efficiency. (The various strands of accountability are outlined and discussed in chapter 3).

Changing values, the threat of globalisation and shifting political ideologies are not the only drivers of NPM practises. The privatisation of public sector agencies, a feature of NPM, has been promoted by various parties, including the World Bank and the International Monetary Fund. The objective of such programmes is to fuel favourable economic climates (Bardouille, 2000). European Commission Directives and the liberalisation of free trade (e.g. the GATT Agreement 1993) have also acted as catalysts for seeking efficiencies in the public sector. The influences and drivers of public sector reform are many and varied. Globalisation has been one of the principal catalysts.

2.5 NPM as a global paradigm

Public sector reform is a global occurrence/paradigm (Yeatman, 1994; Aucoin, 1996; Borins, 1997; Kettl, 1997; Kickert, 1997; Olson et al., 1998; Guthrie et al., 1999; Bardouille, 2000; Pollitt & Bouckaert, 2000; Torres & Pina, 2002). Similar public sector reforms appeared in countries with varying political and economic systems, such as the United States, Korea, the United Kingdom, Portugal, France, Brazil, Australia, Sweden, New Zealand and Canada (Kaboolian, 1998; Torres & Pina, 2002). Reforms have been carried out, principally, in one of two ways: either, ‘let the managers manage’ or ‘make the managers manage’ – phrases coined by Donald Kettl (Kettl, 1997). He describes how the ‘let the managers manage’ movement is based on the belief that heretofore managers knew the right actions to take but were held back by bureaucratic structures, systems and processes that prohibited the realisation of their own and their organisations’ potential. Kettl (1997:455) argues that advocates of this system (such as government in Australia) should recognise that “political support is needed” for managers’ decisions. Protection from harsh recriminations for increased risk-taking in decision-making is also required to support a ‘let the managers manage’ public sector management model (Kettl, 1997).

Followers of the ‘make the managers manage’ movement (namely New Zealand and the UK) are of the view that since government agencies were in many cases monopolies, there was little incentive for managers to manage better. The only way therefore to

ensure better management was to subject them to market forces – competition. Kettl (1997:455) warns advocates of this approach of the need to “allow sufficient time” for implementation before judging its effectiveness. Reforms require time to take hold and substantial investment in people and technology (Kettl, 1997; Lapsley, 2001a). Failure to allow such time may result in an erroneous negative evaluation of reform efforts (Lapsley, 2001a). Reforms have been implemented differently in various other countries. In order to better appreciate NPM reforms in Ireland (see chapter 4), a brief review of the implementation of NPM ideas in key countries (those regarded as leaders in the NPM movement or with close ties to Ireland) is outlined below.

The public sector reforms that took place in Australia during the 1980s were dominated by the philosophy of managerialism (Parker & Guthrie, 1990).² Here the reform movement was based on the idea of ‘let the managers manage’. In Australia, the emphasis was on improving the skills of its key resource, its people, through training and reshaping the civil service system to encourage performance (Kettl, 1997). The gradual and continuous change process there is in contrast to the more radical and rapid changes driving the New Zealand and UK reforms. In 1988, New Zealand abandoned its rule-bound civil service system.³ Large departments were split up into smaller units focused on a specific mission and guided by output budgets (Osborne, 2000). NPM reforms there held fast to certain elements of related theories – public choice theory, principal-agent theory, and transaction cost analysis (Boston et al., 1996; Kettl, 1997; Pallot, 2003).

In the 1990s, the UK introduced over one hundred agencies into their public administration system, each with a performance agreement and greater operating flexibility. Structural change arising from NPM reforms has inculcated a business ethos in agencies and has led to the development of a business culture among local authority managers (Doig & Wilson, 1998). In the UK, performance related pay was introduced in

² Public sector reforms in Australia have been examined by a number of authors, see for example: Guthrie (1993), Boston (2000), Kimber & Maddox (2003).

³ The New Zealand situation has been examined by Boston et al. (1996), Schick (1996), Pallot (1998).

the public sector in 1985 and the focus on the customer increasingly moved from the periphery of the organisation's concerns to the centre (Osborne, 2000). This new emphasis on the customer injected quality of service into organisations' performance standards.⁴

Reforms have been adopted in different ways in the US and Canada.⁵ NPM reforms in EU countries have adopted various approaches. In some cases there has been a transfer of the management of public service provision and public utilities to the private sector. Privatisation of public utilities constitutes a particularly important part of the restructuring programme of the public sector in Austria, Belgium, Finland, France, Germany, Norway, Sweden and the United Kingdom. Concerns with efficiency, effectiveness and value for money are of particular interest to Anglo Saxon countries and the Netherlands. Torres & Pina (2002) note how in these countries the citizen is seen as a consumer of services and viewed as a customer. In the Nordic countries concern centres around meeting citizens' needs. There is a distinctive tradition in these countries of consultation and negotiation and the primary concern is to satisfy citizens' wishes (Torres & Pina, 2002).

Bardouille (2000:95) considers OECD countries to be likely to continue to "inculcate the NPM doctrine into their public service institutions and policy cycles". This is despite the fact that giving primacy to cost considerations is likely to mean a less than equitable distribution of resources. Moreover, Bardouille (2000) argues that the pursuit of such policies is in recognition of the economic fact that globalisation is built on competition and that in order to survive in an increasingly competitive environment, efficiencies have to be sought out and built into government ways of doing business (see section

⁴ The UK situation has been examined by: Humphrey, Miller, & Scapens (1993), Humphrey, Miller, & Smith (1998), Lapsley (2001a).

⁵ The US has adopted parts of both 'let the managers manage' model and parts of 'make the managers manage' model with as a result a divided focus Kamensky (1996), Kettl (1997). In Canada the public service is trying to do more with less by "desperately attempting to restructure, delayer, re-engineer and reinvent itself in the name of efficiency" Bardouille (2000:99). Bardouille (2000) regards these reform efforts as being consistent with the state's efforts to safeguard its interests and sustainability in a globalising world.

2.4). However, implementation of NPM reforms globally has not always been without difficulty or criticism. The problems surrounding implementation of NPM ideas together with criticisms of NPM are examined below.

2.6 Criticisms and Difficulties in implementing NPM Reforms

Difficulties surrounding implementation of NPM ideas include: measurement difficulties in the public sector; negative effects resulting from the drive for increased efficiencies, and the growth of public entrepreneurialism. Furthermore, criticisms of the prevalence of managerialism centre around concerns about the erosion of social democratic accountability. Each of these criticisms is dealt with in turn below.

2.6.1 Measurement Difficulties

More than twenty years after Hood's (1974) assertion of major differences between the private sector and the public sector (see section 2.2), Mintzberg (1996) argues that government activities cannot be managed in the same way as private sector activities. He identifies three key assumptions underlying the private sector view of management which cannot be upheld for public sector management; the first and second of these refer to measurement problems. Firstly, Mintzberg (1996:79) questions whether particular activities in the public sector can be isolated from one another, and from direct authority, and secondly, whether or not performance can be fully and properly evaluated by objective measures. The third assumption queries whether activities can be entrusted to autonomous professional managers who will be held accountable for performance. Mintzberg (1996:79) argues that these assumptions "collapse in the face of what most government agencies do and how they work", noting that it is almost impossible to isolate government activities from direct hierarchical control. To achieve this, politicians would have to "stand clear of the execution of policies", and this does not happen in practice (Mintzberg, 1996:79). He also takes issue with the "myth of measurement", suggesting that many of the benefits of government activities do not lend themselves to measurement in cost terms and that these activities are in the public sector precisely because of measurement problems (Mintzberg, 1996:79).

Measurement in public sector organisations must serve many purposes – the operational needs of employees and the periodic control needs of those at higher organisational levels. In addition “the inability of existing information systems to provide necessary data in a valid, reliable, timely and cost effective manner” militates against the use of information for accountability and performance evaluation in the public sector (Cavalluzzo & Ittner, 2004). In public hospitals accounting information systems need to cater for the information needs of those close to delivering the service, the needs of managers at local hospital level, regional level and also at national level. The measurement of financial and non-financial information needs to be flexible enough to meet local needs whilst also satisfying national ones (Ballantine, Brignall, & Modell, 1998). In addition, the essential nature of the public sector creates difficulties in balancing the need for efficiencies with measures of effectiveness. Measurement must include an assessment of quality in addition to the more traditional efficiency measures at the operational level where quality is actually delivered (Adnum, 1993). However there have been criticisms of public sector organisations who have pursued efficiency gains at the expense of other core public sector values. These are discussed below.

2.6.2 Negative Effects of the Drive for Efficiency

Rosenbloom and Carroll (1990) cite a number of public employee rights cases that demonstrate the need for administrators to balance the drive for efficiency with the values of due process, freedom of speech and privacy. Here is evidence of tension between managerial accountability on the one hand and public/democratic accountability on the other (see chapter 3). An overemphasis on expectations of efficiency can lead to a loss of good practice in human resource management and other areas necessary to sustain a public sector that employees can have confidence in (Rosenbloom & Carroll, 1990). Expectations of efficiency gains from public management reforms are said to be exaggerated (Ferris & Graddy, 1997). Brunsson and Olsen (1997) argue that reforms often are not focused on the public service products and services provided, and in some cases the impact of reforms on the service is different from what was intended. This view coincides with that of Brunsson and Sahlin-Andersson (2000) who argue that in

many cases, in the Swedish context, NPM reforms are focused on the management and control aspects associated with the delivery of public services rather than on the services themselves. They cite education and health as instances of this. Against this, there are examples of improvements in the quality of public services in the UK resulting from NPM reforms, but at the cost of reduced adherence to administrative and financial system controls.⁶ Public sector managers concerned with meeting demands for increased efficiencies are adopting entrepreneurial characteristics more commonly associated with the private sector.

2.6.3 Growth of Public Entrepreneurialism

In addition to the development of a management culture within the public service, new public entrepreneurialism has also developed in the UK (Doig & Wilson, 1998). The growing number of public-private partnerships offered as answers to governments' fiscal and social problems highlights the importance currently attached to both private and public entrepreneurship (Bellone & Frederick, 1992). NPM reforms involve both a structural and managerial dimension (Hoggett, 1996; Thompson, 1997; Doig & Wilson, 1998; Lapsley, 1999; Denhardt & Vinzant Denhardt, 2000). Structural changes in the public sector, for instance in the UK and New Zealand, have reduced job security. As a consequence of this negative effect, managers are not only adopting stronger business attitudes, they are also increasingly seeking greater discretionary powers "as well as independence from political considerations and constraints", in order to give themselves the best possible chance of securing performance rewards and retaining security of employment (Doig & Wilson, 1998:271). This is leading to the growth of a new type of public sector manager – the public entrepreneur. NPM has advanced and favoured a vision of public managers as the entrepreneurs of a new leaner government "emulating not only the practices of, but also the values of business" (Denhardt & Vinzant Denhardt, 2000:549). Doig and Wilson (1998:272) note that this has led to concerns over failings by a number of agencies in areas such as: "the appropriateness of financial

⁶ As reported on by the Audit Commission in the UK, see Doig & Wilson (1998).

controls, compliance with rules, the stewardship of public money, the misinterpretation of performance rewards, a conflict of interest between personal benefit and public service, and the issue of accountability". The strong objection and concern surrounding the development of public entrepreneurialism is that it may undermine legitimate "constitutional values such as fairness, justice, representation and participation" (Terry, 1993; Doig & Wilson, 1998; Terry, 1998; Denhardt & Vinzant Denhardt, 2000). This is not a new objection. Tyson (1987:76) warned that "individualism and the 'survival of the fittest' through the market mechanism, do not accord with a desire for the public good".

Reform must constantly tread a line between searching for ways to increase efficiency on the one hand whilst keeping in mind public interest on the other (Kettl, 1997). This fine balancing between multiple objectives derives from the special characteristics of the public sector which were outlined in section 2.2. The concept of public entrepreneurship "cultivates and perpetuates an overly romantic view of public administrators... as conquerors and heroes" (Terry, 1993:394). He cites examples in the US of abuse of power by public entrepreneurs and recommends that any model which sanctions this entrepreneurial form of power and control in a democratic society should be vigorously abandoned (Terry, 1993). The public entrepreneur as "innovator and radical ground breaker may not be in the best interests of society" (Terry, 1993:394). Sometimes adherence to due process through detailed rules and procedures may be favoured in the best interests of society (Terry, 1993; Hood, 1995a). It is this tension between managerialism and social democratic concerns that fuels the public sector reform debate. The popularity of the movement away from progressive public administration to NPM and increasing 'managerialism, from the early 1980's, was not regarded as universal (Hood, 1995a). Though a proponent of NPM, Hood argues that there may be some circumstances in which a move towards 'progressivism'⁷ in administrative design may be more appropriate than a move away from it (Hood, 1995a). Writers such as

⁷ Hood (1995a:167) defines progressive-era administration of the late 19th and 20th century, as an era concerned with a growing "idealisation of professionalism and science" and "a distrust of organized crime, corrupt politics, and monopoly politics".

Bardouille (2000:91) are concerned that public sector managers will be seen as assuming the role of entrepreneurial leaders and that they “will become self-interested and opportunistic”. She argues that “the notion of the entrepreneurial bureaucrat is clearly not congruent with the public interest and democratic stewardship” (Bardouille, 2000:101).

Prior to the series of NPM type reforms, devices were in place to ensure honesty and neutrality in the public service. These included fixed salaries, rules of procedure, permanence of tenure, restraints on the power of line management, and clear lines of division between public and private sectors (Hood, 1991:16). However, changes brought about by NPM have taken away several of these mechanisms or made them ineffective (Doig & Wilson, 1998). Against this, Parker (1999:221) states that there is evidence that under privatisation of public services in the UK, there have been real economic gains to the benefit of both consumer and investor. Consumers have benefited from not only lower prices but also improved quality of service, whilst investors have benefited from dividends and capital growth (Parker, 1999). However, this finding is not supported by the Torres & Pina (2002) study of public service delivery in eleven EU countries.⁸ Torres & Pina (2002:46) argue that there is “no hard evidence of improvements in efficiency and quality after externalisation” (the transfer of management of public services), whilst the beneficial outcome of privatisation (the divestment and deregulation of the public sector) is, they consider, “debatable”. It is questionable then whether the benefits gained by growing managerialism offset social democratic considerations.

2.6.4 Subordination of the Social Democratic Role of Government

The implementation of NPM reform has led to a number of problems. The speed of change within organisations has given rise to a persistent struggle between such

⁸ This lack of support in findings may be because of the differences between the two studies. The Torres & Pina (2002) study was based on survey results from local authorities in twenty cities across eleven northern and southern European countries including the UK. The Parker (1999) study concerned regulated utilities in the UK only.

objectives as “speed of delivery, cost-cutting and performance by results on the one hand, and adherence to due process, procedure and precedent on the other” (Doig & Wilson, 1998:271). Landry (1993:348) asserts that “equity is more important than efficiency in the operation of public bureaucracies”. Government is overlooking its social democratic role as it becomes more concerned with managing its role using elements of recognised global public sector reforms (Bardouille, 2000). Evolving control frameworks under NPM are weakening the priority given to equity concerns in policy design and implementation (Landry, 1993; Van Wart & Berman, 1999). This conflict between social democratic considerations on the one hand, and the drive for increased efficiencies on the other, is at the heart of debates over public sector management reforms. A market led approach to the business of government and the subsequent discharge of accountability solely in efficiency, effectiveness and responsiveness terms is deficient as a measure of accountability (Kickert, 1997; Denhardt & Vinzant Denhardt, 2000). Other social democratic concerns must also inform the public management process. Denhardt & Vinzant Denhardt (2000:549) believe that NPM has moved a step too far, from the role of government as “rowing” under old style public administration, to “steering” under NPM.⁹ Denhardt & Vinzant Denhardt (2000:557) argue that notwithstanding that NPM has been recognized as the dominant paradigm in the field of public administration and governance at present, “concern for democratic citizenship and the public interest has not been fully lost, but rather subordinated”. This concurs with Painter (1990) and Hood (1995a) who suggest that ideals not emphasised in the current reform movement will be reasserted at a later date (see section 2.4).

2.7 Summary

This chapter has defined and described the characteristics of the public sector, noting how management of this sector is more complex in many ways than in the private sector, because of its special characteristics, i.e. its funding mechanisms, ambiguous goals and objectives, non-measurable outputs, multiple constituencies as customers, and the

⁹ ‘Steering and rowing’. This description was first used by Osborne & Gaebler (1993).

existence of extended decision making processes. In addition the principles inherent in the public sector distinguish it from the private sector, among them: selflessness, integrity, objectivity, accountability, openness, and anonymity. The nature, substance and spread of NPM was examined. The important components of accountability, performance measurement and the role of accounting in performance measurement are outlined in detail in chapter 3. Public sector reforms have been implemented globally in different ways. An increased focus on managerialism has been witnessed in the global spread of NPM type reforms; in fact, most discussions around NPM centre on the fact that it is based on managerialism. In some cases this extends to public entrepreneurialism. Even where such a radical approach is not encouraged, there is increased pressure to move to a customer centred focus. Once this happens the logical next step in the process is evaluation through performance measurement, which moves the focus away from inputs to outputs, and then perhaps to outcomes in more developed performance measurement systems. This increasing focus on managerialism and, at its most extreme, public entrepreneurialism, has not occurred without problems, among them a growing tension between the erosion of social democratic values and a greater role for managerialism in an attempt to respond to globalisation pressures.

It may now be possible, based on the above descriptions and accounts of NPM, to attempt an answer to Stark's question, "what makes the New Public Management new?" According to Khademian (1998) in the Westminster systems (Canada, UK, New Zealand and Australia) and in the United States of America have found common ground in defining what makes the NPM so new. It is new because:

performance should now replace the focus on process accountability; citizens should be viewed as customers and should define and assess performance; short-term contracting with a performance driven focus should take precedence over vertical integration in defining responsibilities and ensuring the best delivery of goods and services; devolution and flexibility should replace rulebooks and centralisation of executive power; and incremental budgets should be replaced by a transparent budget process with a focus on performance indicators. (Khademian, 1998:270).

However, what is still unclear from a review of the NPM literature is clear-cut advice for governments on how to achieve a balance between trying to improve efficiencies in the

public sector, through increased emphasis on managerial accountability, with concerns for the erosion of democratic and constitutional accountability in doing so. The nature and core of the changing focus of accountability is explored in chapter 3.

CHAPTER 3

CONCEPTUAL PERSPECTIVE: ACCOUNTABILITY, PERFORMANCE MEASUREMENT AND ACCOUNTING

3.1 Introduction

The growing concern with managerialism manifests itself as a concern with accountability. Increasingly the focus is on managerial accountability and away from other forms of accountability – public, democratic and constitutional accountability. This chapter provides a comprehensive discussion of the full nature of accountability with a particular focus on the elements of accountability both emphasised and increasingly ignored by the growth of NPM practices. The development of performance measurement practices has been central to the implementation of NPM ideas outside of Ireland. Accounting information is a key element of performance measurement. For example, in a study of reforms of the UK's NHS (National Health Service) 1970-2000, Lapsley (2001a:349) concluded that “accounting has become accepted as an essential ingredient of all modernising reforms in UK health care policy”. The changing nature and use of accounting information in NPM contexts is examined in this chapter. This provides a background for the discussion of the use of accounting in Irish hospitals which follows in the case study chapters (see chapters 7-10).

The outcomes emanating from the proliferation of NPM ideas, values and practices include a change primarily in the implementation and control aspects of management. Management control is the process by which managers endeavour to ensure that resources are not only obtained but used effectively and efficiently in the accomplishment of the organisation's objectives (Anthony, 1965). However in the public sector, very often managers do not have control over the acquisition of resources. Management control in non-profit organisations is a “regular systematic process with steps repeated in a predictable way” (Anthony & Young, 1999:5). Whilst these are functionalist definitions of management control, they are useful starting points for an examination of contemporary public sector management. The ideas, components and

techniques of NPM detailed in Table 2.1 (see chapter 2) are most evident in the control aspects of the public sector management process, for example, hands-on professional management, explicit standards and measures of performance, and greater emphasis on output control. Although the seeds of performance measurement were sown in the 1960's, issues of accountability attracted more interest and gained increased scope since the advent of NPM. The growth and implementation of NPM practices in organisations has resulted in a greater focus on issues relating to management control (section 3.2) such as accountability (section 3.3 and 3.4) and performance measurement (section 3.5). This study sees these issues as central to the implementation of NPM reforms. A thread connects these concepts of control, accountability and performance measurement. NPM demands greater accountability via improved performance measurement in return for a relaxation of central controls and greater autonomy for public sector managers. Each of these NPM concepts is discussed in this chapter, as are the difficulties of an increasing role for performance measurement in specialised organisations, such as hospitals, staffed by professional groups. The discussion of performance measurement (in section 3.5) is followed by an examination of the nature of accounting and the role of accounting (in section 3.6) in the expansion of performance measurement and the implementation of NPM reforms. One outcome of NPM reforms is that the role of public sector managers has grown in importance and has been accompanied by a simultaneous "weakening of trust in professionals" (Hood, 1995b:98). This feature of NPM reform outcomes is pertinent to this current study of the implementation of NPM reforms in four Irish hospitals, and therefore a discussion of organisational trust is developed in section 3.7 prior to a summary of the chapter in section 3.8.

3.2 Increased Control

Hood (2002:311) interprets NPM as a public-service reform movement that involves an attempt to change the way public-service organisations are controlled. He sees "a thermostatic vision of control over bureaucracy" as one central and recurring element of the managerialist public administration debate (Hood, 2002:311). By this he means "specifying a set of desired policy outputs, making the person in charge of the public

organisation directly responsible for delivering those outputs, and giving them some degree of decision-making autonomy for this purpose” (Hood, 2002:311). He considers that this output oriented approach to control has the underlying purpose of allocating risk, blame, responsibility, and reward among senior public bureaucrats and also other actors in the system. If this vision of control is accepted then public managers have limited discretion in deciding on how public services should be delivered. Hood (2002) considers that there is evidence of this type of control in public service reforms in many countries: in the 1993 US Government Performance Results Act, the New Zealand output contract reforms of the 1980s, and the 1990s agency reforms in the UK. There is some evidence of this form of control in the Irish public sector (see chapter 4). From the outline of Hood’s thermostatic control idea it becomes clear that there is increased formality of systems to effect control in public sector organisations.

One implication of this thermostat approach to managing public sector organisations is that elected officials (government ministers) now indirectly steer the public organisation through the settings they select for the policy thermostat (Hood, 2002). However, Hood observes that for this system of control to work, the process of setting performance targets must be transparent, and that the published targets are the ones that matter. This observation presumes that good quality performance indicators are available, which they may not be. This is a simplistic model of control. A thermostatic system of control prevents continuous ad hoc intervention by politicians in adjusting targets. However, for it to function effectively, public service managers must cooperate with the “detector element” of the control system, and they must also facilitate the monitoring activity that gathers information to allow assessment against targets (Hood, 2002:314). To encourage public managers to meet the goals set by politicians, there must be not only positive but negative feedback mechanisms in place.

Public managers must recognise the targets set as feasible and must take “responsibility for results achieved relative to targets, with the corresponding career risks associated with the assumption of blame” (Hood, 2002:315). It is assumed that effective

inducements make managers eager to reach their targets. These inducements could take the form of “intangible reputational effects such as league table performance or could also be in the shape of career risks by way of future contract renewal/augmentation, and/or salary and performance bonuses” (Hood, 2002:316). One motivation for politicians to choose to implement the thermostat control model is the “presumed ability for elected politicians to shift blamethrough delegation” (Hood, 2002:316). However, it may be more complicated than this to effect control of public sector organisations. There may be a lack of instrumentality – it may not be possible to pull a lever to generate results. A prerequisite for delegating managerial authority is a running costs system that permits operational managers to alter the mix of staff and other inputs (Barzelay, 2001:31). This may not always be possible in public sector organisations.

Performance measurement and accounting are fundamental elements of accountability. A preoccupation with performance measurement not only emerged but endured as a feature of NPM reforms since the 1980’s (Hood, 1995b; Olson et al., 1998). There is evidence of a greater reliance on “quantitative, primarily accounting-based indicators” to facilitate organisational control in public sector organisations (Modell, 2004:39). Both performance measurement (see section 3.5) and accounting (see section 3.6), as large components of accountability, are also examined in this chapter. A consequence of any perceived shift in blame within the control system is a reduction in co-operation by those members to whom the blame is perceived to be shifting. This raises the issue of trust as a consideration in implementing NPM ideas in public sector organisations. This underdeveloped dimension has been overlooked in previous studies of NPM but will be considered in detail in this chapter (section 3.7, after a more complete discussion of accountability).

3.3 Accountability in an NPM context

Accountability is more than a process of showing how money is spent. Power (1994) describes how it requires a demonstration that money has been used efficiently, effectively, and for the purposes for which it was allocated. He observes that many audit

practices have grown because of changes in public sector management and increasing concerns about quality, governance and accountability (Power, 1994). Osborne (2000) believes that the essential tenet at the core of public management is allowing organisations flexibilities in return for significant accountability for results. He notes how in Britain and New Zealand, as part of NPM, managers were empowered to control their budgets and manage their staff. Each year these managers had lists of targets and were held personally accountable for their organization’s performance (Osborne, 2000).

In his seminal paper, Hood (1991) outlined seven doctrinal components of NPM, which as noted later (Hood, 1995b:95) were associated subsequently with NPM by many writers. An examination of Table 1 in Hood (1995b) provides justification for each doctrine. However, whilst there is a good fit between the justification and the doctrine for six of the seven doctrines, this is not the case for Hood’s doctrine number five (in the final row of Table 3.1 below).

Table 3.1: Outline of Hood’s doctrinal components of NPM and justification for them

No. *	A Typical Justification for the doctrine		The doctrine
1	Make units manageable; focus blame; split provision and production to create anti-waste lobby	How?	Unbundling of the public sector into corporatised units organised by product
2	Rivalry is the key to lower costs and better standards	How?	More contract-based competitive provision
3	Need to apply proven private sector management tools in the public sector	How?	Stress on private sector styles of management practice
4	Need to cut direct costs, raise labour discipline and do more with less.	How?	More stress on discipline and frugality in resource use
6	Accountability means clearly stated aims, and efficiency needs hard look at goals.	How?	Explicit formal measurable standards and measures of performance and success
7	Need for greater stress on results.	How?	Greater emphasis on output controls
5	Accountability requires clear assignment of responsibility not diffusion of power.	How?	More emphasis on visible hands-on top management

Source: Hood (1995b:96). * Hood’s original numbering of doctrines.

The “typical justification” that “accountability requires clear assignment of responsibility not diffusion of power” does not fit well with the doctrine “more emphasis on visible hands-on top management”, as in most public sector organisations increased accountability requires more than increased visibility of hands-on top management to secure it. In part the weak connection between the justification and the doctrine may be because of the complex and multifaceted nature of accountability, which is discussed in section 3.4

3.4 The Changing Nature of Accountability

One of the two features which dominate NPM is a shift in emphasis from process accountability to accountability in terms of results (Hood, 1995b; Boston et al., 1996; Khademian, 1998). It is this changing nature of accountability and the role of accounting in supporting that change that is distinctive. Ezzamel & Willmott (1993) and Lapsley (1999) have noted an increasing emphasis on financial accountability as part of the reforms. A second distinguishing feature of NPM reforms is the removal of differences between the public and private sector. A changing focus for accountability has supported the removal of those differences. Ferlie et al. (1996) distinguish between two dimensions of accountability, political and managerial.¹⁰ Political accountability is “about those with delegated authority being answerable to the people” (Ferlie et al., 1996:316). This form of accountability is also known as public, democratic or constitutional accountability and consists of two parts: “the giving of an account, and the subsequent holding to account” (Stewart, 1993:17). This description of public accountability centres around stewardship, one of the earliest roles that accounting fulfilled in organisations.

Power (1994) notes that the continuing development of NPM has seen public accountability reframed in relation to concepts such as goal definition, efficient allocation of resources, and financial performance. While effectiveness of service

¹⁰ In the New Zealand public sector context, Pallot (2003) describes this tension between the managerial form of accountability and the public of accountability as a tension between the privatisation and democratisation agenda (see also section 2.4).

delivery remains an ideal, it is only one (often minor) element of managerial language in the public sector (Power, 1994). Hood (1995a:171) questions whether “systems designed with the intention of making government more ‘transparent’ to accountants, may in the process obscure other aspects of public accountability”, by making government harder to understand. The introduction of concepts such as accrual accounting, whilst offering benefits, may make it increasingly difficult for non-accountants, who do not understand the technicalities of accounting, to understand the business of government.

Efficiency is only one of a number of aspects of public sector performance that should concern governments (Pallot, 2003). Other factors of importance include: effectiveness of outcomes, social justice, legality, legitimacy and probity (Pallot, 2003:135). Pallot considers that managerial accountability has been promoted in New Zealand at the expense of democratic accountability.¹¹ She argues that managerial accountability dislodged public accountability there, in respect of concerns such as “outcomes, social justice and the legitimacy of processes” (Pallot, 2003:151).

Managerial accountability is “about making those with delegated authority accountable for carrying out agreed tasks according to agreed criteria of performance” and “can be seen as much more confined and bounded in nature than political forms of accountability” (Ferlie et al., 1996:316). In line with NPM principles, public managers are increasingly held to account largely in terms of efficiency, cost effectiveness, responsiveness to market forces, and satisfaction of customer preferences (Kaboolian, 1998; Denhardt & Vinzant Denhardt, 2000). In order for this managerial system of accountability to work, competition must exist, information about choices must be available, and there must be a capacity to make and exercise choices. This is not how the public sector works in many countries, including Ireland. Public services are frequently provided by only one organisation, and therefore there is little choice.

¹¹ New Zealand has been a leader in NPM reforms (see chapter 2). Reforms there have been embedded since the early 1980's.

However, Hogget (1996) observes the increasing promotion of competition without markets. He provides examples of this in the UK context in social housing and urban renewal schemes, noting how “narrow concepts of performativity, rather than equity” are used as the criterion for resource allocation (Hoggett, 1996:12). This concept of non market competition is used in the funding allocation for the Irish acute hospital sector (see chapter 6).

As noted above, there is a growing tension emerging between democratic/public and managerial accountability. Public sector managers are encouraged to be entrepreneurial and to use incentives to improve the performance of systems and people within their control (Terry, 1995). However, the market-oriented model of public managers is problematic for democratic governance as it implies that public managers are motivated by self-interest and act opportunistically (Terry, 1995). Contracting-out (a feature of NPM reforms) involves some decrease in accountability by transferring the provision of public services to members of the private sector who are generally not subject to the same accountability requirements as public officials (Mulgan, 1997). Mulgan suggests that reduction in such accountability may be one of the reasons for the greater efficiency of the private sector. Yet he counters these arguments by suggesting that, as a result of the contracting-out process, “accountability may on occasion be increased through improved departmental and ministerial control following from greater clarification of objectives and specification of standards” (Mulgan, 1997:116). There is an appeal for those charged with providing greater levels of service to adopt the market model to extract efficiencies, yet there is a concern that in doing this issues associated with democratic accountability – equity and due process for instance – will be sacrificed in the process. Those responsible for service provision take comfort in believing that in the process of adopting the market model of public service provision, greater attention will be paid to defining objectives and standards of service delivery. However, this does not compensate completely for concerns with public accountability.

Kickert (1997:731) contends that “the one-sidedness of managerialism is unsuited to the public sector”, as the public sector is necessarily different to the private sector. He argues that public management requires much more than running government efficiently and effectively. The move away from political accountability to managerial accountability “implicit in NPM, may be a consequence of the diminished legitimacy of the state” (Common, 1998:444). Governments unable to favourably influence macro variables such as unemployment and productivity are adopting private sector business methods in an attempt to extract greater efficiencies from a growing public sector. However, Pallot (2003:149) observes how in New Zealand, there has been “a global sea-change in thinking about the public sector favouring democratisation rather than privatisation”. She argues that there is increasing concern now with the wider political and social context within which government operates, rather than with the internal management of government. Whilst the focus in the early years of NPM reform was on managerial accountability, there is a growing concern there that democratic accountability has been eroded. This interest in re-assessment in New Zealand may cause other governments to reconsider the significance given over to managerial accountability concerns in the implementation of NPM ideas.

Performance measurement is an important part of the NPM toolkit in aiding organisations and their members to discharge accountability. For example, in countries such as the UK, USA, Norway, the Netherlands and Australia, the growth and use of performance measurement has been widespread (Johnsen, 1999). Australia and New Zealand, two countries regarded as leading reformers, have shown that performance measurement is crucial to the reforms (Kettl, 1997). A review of the role of performance measurement in discharging accountability follows.

3.5 Performance Measurement

To further attainment of the goals elected government might set, there must be a report on or quantification of outcomes, otherwise it is difficult to assess accountability (Faucett & Kleiner, 1994). There is an onus on “the professional public sector manager

to deliver a quality product efficiently, and without performance measurement this is not likely to happen" (Faucett & Kleiner, 1994:70). Yeatman (1994:290) makes a clear link between accountability and performance measurement when she states that if agencies are expected to get the best value for money they must "be given financial flexibility and responsibility within requirements of accountability to broad guidelines" . She argues that if managers are expected to be more proactive in management this will mean a reduction of some control within the system and "greater reliance on information giving and receiving through various forms of accountability" (Yeatman, 1994:290). Various strategies exist for achieving improved control of public sector organisations, including: the promotion of competition between public sector units to perform in efficiency terms, and the development of comprehensive performance management information and techniques to support less involvement from the top of the organisation in the delivery of services (Hoggett, 1996). The idea of greater information flows fits well with Hood's basic thermostatic vision of control which requires regular and relevant information, in addition to the other factors outlined in section 3.2, to facilitate its working.

The growing demand from society for greater accountability for results is changing governments' demands on public sector organisations' performance reporting (Cheung, 1996). With the rapid reduction in the cost of electronic information systems, governments are more and more relying on various types of performance indicator to acquire and maintain control of public sector managers (Smith, 1995), particularly in electorally sensitive areas, such as education and housing management. A further reason for the proliferation of performance controls in the UK is that, although they may not be the means by which control is maintained, they are instead "the means by which senior officials maintain an illusion or simulation of control within a decentralised system" (Hoggett, 1996:23). The growth of large decentralised organisations, to accommodate specialisation, is also increasing the need for performance measurement. One way for senior managers managing at a distance to secure greater control over organisational activity is to "invest more heavily in accounting information" (Roberts & Scapens, 1985:453). The value of this information depends in part on its relevance and on its

quality. Acute hospitals are increasingly large specialised organisations. Whether increased use of accounting is being used to monitor performance is at the core of this study. There is also a focus on the manner and effectiveness of use of this information and its potential to aid reforms.

The diffusion of performance management systems has clearly had the effect of reducing professional autonomy across a wide number of different sectors (Hoggett, 1996). Medical treatment provided within large specialised organisations “is efficient organisationally” (Abbott, 1988:193) and it is this “increasing value of organisational efficiency”, a key objective of NPM reforms, which directly impinges on the standing of the professions relative to other organisational groups. It leaves them little choice but to become employed in such organisations (Abbott, 1988). There is evidence in previous studies of an enduring and persistent conflict between managers and clinicians when the autonomy of clinicians to work independently is threatened by administrative values which are not consistent with those of the professional (Wilensky, 1964; Freidson, 1970, 1975; Abernethy & Stoelwinder, 1991; Jones & Dewing, 1997; Kurunmaki, 1999). Financial controls such as budgets are an example of administrative controls (Abernethy & Stoelwinder, 1995). Conflict is likely to arise in organisations staffed by groups which have a “high professional orientation” and who are controlled by output forms of control, where performance is measured against imposed targets (Abernethy & Stoelwinder, 1995:13). The introduction of NPM reform in public acute hospitals is an attempt to increasingly control the work of occupational groups in the hospitals, among them consultant hospital doctors.

Murphy (1990:72) argues that professionals, such as doctors, as salaried employees, “have lost their traditional autonomy” and are subject to a bureaucratic system of managerial control in formal organisations such as hospitals. He argues that one reason professionals employed in bureaucracies are dissatisfied is that they are now subject to the control of “bureaucratic administrators and state regulation” (Murphy, 1990:79). In many cases they do not consent to increased modes of control (Jones & Dewing, 1997;

Kurunmaki, 1999). Others see the employment of professionals (such as doctors), in bureaucracies (such as hospitals), as increasingly “routinising” and consequently deskilling those professionals (Freidson, 1986:109). Freidson (1986:119) argues that employment implies “the loss of capacity to control work” – not only the loss of control over the economic return from the work, but also loss of control over “what work is to be done, and how it is to be done”. Yet Abbott (1988) argues that the hospitals’ division of labour initially granted doctors “domination”, and has preserved their autonomy over the years.

A further cause of discontentment of professionals in large bureaucracies is that lower ranking professionals, who were traditionally powerless, are beginning to seek some of the power of the well established professions (Murphy, 1990:79). Within the medical profession, as with other groups, there is specialisation, “differentiation” and therefore heterogeneity (Abbott, 1988:118). Reforms may be accepted more easily by some parts of the professional group than by others. Accepting NPM reforms may be an attempt by some professional groups to advance their own standing vis-à-vis other professions within the same work setting. For instance, in Sweden, some nurses, especially those who identified themselves as “administrative leaders” as opposed to “experts in caring”, accepted managerial reform initiatives, in the belief that their new position offered greater “acknowledgement” of their position relative to that of the medical profession (Blomgren, 2003:66).

The foremost change in legitimisation in the professions has been a move from “reliance on social origins and character values to a reliance...on rationalisation of technique and on efficiency of service” (Abbott, 1988:195). This changing view of the professions echoes changing values in society. It has resulted in increasing pressure on the professions to “move towards new legitimacy bases or face erosion of jurisdiction” (Abbott, 1988:195). This implies that change is almost inevitable in a society which does not stand still. (The changing societal context surrounding NPM reforms in Ireland is outlined in chapter 6.) A great deal of the influence of the modern professions stems

from their “control over the selection of new recruits, the socialization of successors, and control over conditions of incumbency” (Powell & Di Maggio, 1991:191). Powell and Di Maggio argue that “skilled institution builders who gain from such a system of power will typically expend considerable effort to maintain their dominance” (Powell & Di Maggio, 1991:191). Acute hospitals are typical of large organisations consuming substantial portions of government monies (see chapter 6) and yet not meeting the service expectations of citizens. In implementing NPM reforms there is an attempt to raise the status of management, and references are increasingly being made to the “professional public sector manager” and merit based systems of reward (Faucett & Kleiner, 1994:70; Bardouille, 2000). There are considerable pressures on these organisations, and on the professions working within them, to succumb to NPM forces. Evidence of both the ease and difficulty with which NPM ideas are being implemented in four acute hospitals is provided in chapters 7-10. The introduction of NPM reforms has led and continues to lead to a focus on managerial issues outlined earlier in this chapter. The expansion of the performance measurement process (to discharge accountability) is not neutral and is likely to meet with resistance in bureaucratic organisations employing groups with strong professional orientations. This chapter continues by identifying problems and difficulties with performance measurement systems and processes.

The essential logic of performance measurement requires it to focus on outcome rather than output measurement (Kettl, 1997). This then facilitates a comparison of outcomes against desired policy objectives. However, Kettl (1997:450) notes the difficulties encountered when developing outcome measures, given that a “multitude of factors may influence an outcome”. Therefore output measures (i.e. only partial outcome measures) in the form of performance indicators are commonly used instead of outcome measurement. However, performance indicators are frequently criticised (Mullen, 1985; Smith, 1990; Miller, 1992; Likierman, 1993; Miller, 1996; Behn, 2003). Mayston (1985:56) argues that performance indicators need to be strengthened to include “the fundamental accounting attributes of decision relevance and reliability”. A problem

with performance indicators is that they often transform demands for accountability into measures that are more appropriate to the “needs of external monitoring agencies”, rather than the information needs of customers (Miller, 1996:59). In some cases, performance indicators are merely instruments for allocations, rather than information resources for decision-making by end users (Miller, 1996). Moreover, “what is counted usually counts, and the counting of it has effects” (Miller, 1992:71). By implication the decision therefore to develop performance measures in one area can have effects on other parts of a public service not placed under the performance measurement microscope. In addition, there is some concern that performance indicators are not robust, and that they may modify behaviour so that the indicators are improved regardless of whether performance actually improves (Mullen, 1985). Kettl (1997:457) suggests that if the “objective of the performance measurement process is to improve results rather than to produce results then, what is required is a system not based on performance measurement but rather one focused on performance-based management”.

With the growth of performance measurement, efficiency benchmarking is increasingly a reality. This involves making tough assessments of the comparative performances of various organisations (Van Wart & Berman, 1999). There is evidence not only of efficiency benchmarking in use in the Irish health sector, but also of non-market competition to allocate annual recurrent funding to hospitals. Funding allocations in the acute hospital sector are partly made on the basis of the casemix cost model.¹² Under the casemix model hospitals regarded as efficient (whose aggregate cost per procedure is less than the national benchmark cost) receive additional funding, whilst inefficient hospitals are penalised – evidence of the use of accounting information in the

¹² Casemix involves both the measurement of individual hospital output captured by the Hospital In-Patient Enquiry (HIPE) system, and the comparison of cost and activity between peer group hospitals. In Ireland, hospitals are divided into Band 1 Hospitals (the 7 largest hospitals including Ashford Hospital, see chapter 7) and Band 2 hospitals (25 hospitals including Maria Theresa Hospital, see chapter 8, and Southop, see chapter 10). Hospitals are grouped in these differing groups/bands so that they are only benchmarked against their peers (Grealy, 2004). In the Irish case, each hospital’s cost-per-case is compared with the national mean to provide a type of VFM measure in arrears (Grealy, 2004). Ireland “was the first country to introduce a ‘budget-neutral’ system whereby savings generated were reinvested in hospitals who demonstrated that additional funding to them would result in real benefits (Grealy, 2004:6).

performance measure process. Accounting information is a “key ingredient in the managerial decision-making processes” in both public and private sector organisations (Pettersen, 2001:561), and in other countries accounting has been central to the implementation of change programmes across the public sector (Guthrie & Humphrey, 1996; Guthrie et al., 1997; Olson et al., 1998; Guthrie et al., 1999; Hopper et al., 2001; Newberry & Barnett, 2001). The role, use and influence of accounting information is examined in section 3.6.

3.6 Accounting and Performance Measurement

Accounting “can play a role in organisational and social affairs” (Hopwood, 1990:9). Hood (1995a:171) argues that what we saw in the early 1990’s was a return to the utilitarian ideas about public management which were developed over 150 years ago, placing heavy stress on accounting practices. This connects with Painter’s (1990) argument that certain values not emphasised in the current wave of reform will be reasserted at a later date. Heretofore, hospitals, guided by a non-economic philosophy, had not made a significant investment in the “accounting craft” (Hopwood, 1990:16). However, in Australia, New Zealand and the UK, there is evidence of substantial changes in the nature of financial management information systems coinciding with changes in public sector management generally (Schick, 1990). Pollitt (1988:96) observed that there is a “tremendous emphasis on new accounting procedures” in countries adopting NPM type reforms. In New Zealand, accounting was seen as a primary tool of change in the new accountability system (Alam & Lawrence, 1994). Brunsson, Lapsley & Miller (1998) consider that there are now pressures for a new visibility for accounting in health care. With the increasing economic discourse in the health care area one might expect to find an even greater role for accounting in health care organisations in 2005. This is examined in the Irish context in the four case study chapters.

The public sector has always posed challenges for management accountants. On the one hand the characteristics of organisations have an impact on the accounting that is

practised (Jones, 1992; Glynn, 1993). On the other hand the choice of accounting technique can influence behaviour in the organisation (Lapsley, 1992). Once an accounting system has been set up and integrated in an organisation it becomes involved in organising and modifying organisational life. It is a key element of the organisational communication system (Broadbent & Guthrie, 1992). In public sector organisations, choosing an accounting technique from the many available is not clear-cut. Power and Laughlin (1992:133) suggest “accountingisation” as a term for what they see as a colonising force in the public sector, noting that “accounting as method may eclipse broader questions of accountability”, in so far as it can only capture quantifiable measures of performance.

Hood (1995b:94) regards accounting as a key element in the introduction of NPM and the new “conception of accountability”. He suggests that we may be facing “public administration by numbers” and questions whether this elevates bottom-line efficiency concerns at the expense of other, less quantifiable values (Hood, 1995a:170-171). Organisations which place too great an emphasis on financial accounting information may reduce accountability by focusing on the less important (Hyndman, 1990). In Hyndman’s study the information needs of people supporting and funding charities were highlighted. These individuals and groups were concerned with wider issues of accountability other than just financial accountability. Here again is that tension between managerial accountability and democratic accountability, discussed in section 3 of this chapter.

There are others who advance the importance of accounting. Macintosh (1994) considers that Accounting Control Systems are critical to the functioning of organisations responsible for producing society’s goods and services. These systems are involved in the management of society’s largest organizations, both private and public sector ones (Macintosh, 1994). Using management accounting techniques, people or units are made accountable for certain activities and results. The financial account of the organisation allows comparison with past performance and with performance of other

organisations (Hopwood & Miller, 1994), and facilitates the efficiency benchmarking mentioned earlier. In addition to providing information to monitor cash flows, accounting information is used “as a surrogate measure for other aspects of operational performance” (Otley, Broadbent, & Berry, 1995:33). Otley et al. (1995:34) argue that the “process of generating feedback information is fundamental to management accounting on which much management control practice rests”. The thermostatic vision of control envisioned by Hood (2002) requires the accounting system to generate feedback information to facilitate this form of management control. This requires a choice and use of appropriate accounting techniques.

There is a variety of accounting practices and techniques that are available to managers of public sector organisations. These include not just the provision of financial information, but also practices and techniques such as the delegation of budgets, the development of performance indicators and many others (see Table 3.2).

Table 3.2: Increased Visibility of Basic Accounting Techniques and Practices

Technique / Practice
Recognition, measurement and apportionment of revenues and costs
Allocation and delegation of budgets
Establishment of performance indicators
Methods of formula funding
Verification devices to monitor performance and control resources usage e.g. VFM audits
Cost improvement programmes

Source: Humphrey & Scapens (1996) and Humphrey & Olson (1995)

Hood (1995b:96) details some possible accounting implications of NPM reforms including: “more cost centre units, private sector accounting norms, more stress on the bottom line, fewer general procedural constraints on handling of contracts, cash and staff”. He argues that changes in public sector management are coupled with more use of financial data for management accountability, performance indicators, audit and



greater emphasis on identifying costs and understanding cost structures – private sector practices being imported into the public sector.

Examining the use of accounting at a macro level, i.e. at governmental level, Guthrie et al., (1999) found that across countries where there is evidence of NPM governments and agencies are drawing on a large list of accounting-based financial management techniques in the pursuit of reform. This emerging field they described as New Public Financial Management (NPFM) (Guthrie et al., 1999). They identified five different categories of NPFM reforms: changes to financial reporting systems, including the promotion of accrual-based financial statements; the development of commercially minded, market oriented management systems and structures to deal with the pricing and provision of public services; the development of a performance measurement approach, including techniques such as financial and non-financial performance indicators, league tables, output and outcome performance measures and benchmarking; delegation of budgets; and changes to internal and external public sector audits (Guthrie et al., 1999). They see NPFM reforms as having the capacity to change the ruling language and priorities in organisations. In this way they agree with Hood (1995b:93) that “accounting plays a significant role in implementing NPM ideas”. One aspect of accounting that all public managers are familiar with is the area of budgets. Traditionally budgets were used in the evaluation of performance and attribution of responsibility for outcomes to organisational members (Burchell, Clubb, Hopwood, Hughes, & Nahapiet, 1980). Now budgets have a critical role to play in meeting increased demands for accountability for results, by assigning costs to outputs (Hood, 1996). Given the increasing focus on public sector outcomes rather than process, one might expect to find an expanding rôle for financial information as a dimension of performance management of public sector organisations. This aspect is considered in the Irish context in the case study chapters (chapters 7-10).

Hospitals managers, in many cases, lack sufficient information to address resource management questions and enhance hospital performance (Stoelwinder & Abernethy,

1989; Truman, 1990). Hospital information systems need to address the needs of diverse groups: hospitals employees responsible for resource allocation decisions, senior hospital managers, and management at regional and national level. Preventing access by design or tolerance of weak financial systems has implications, among them the undermining of some professionals (in this earlier study, nurse managers), by constraining them from “gaining access to desired and what they consider to be necessary information” (Covaleski & Dirsmith, 1986:210). In other studies some nurse managers have shown a willingness to accept greater responsibility for resource management and budget responsibility, if it is properly resourced and accompanied by discretion and authority (Purdy, 1993). Where nurses “interacted with budgets”, were provided with accounting data, and appreciated the accounting data, “natural learning” occurred Purdy (1993:295). Failure to supply such information to willing groups therefore results in lost opportunities for engagement in learning and understanding of the role and uses of accounting information. Ballantine, Brignall, & Modell (1998) argue that improvements in performance for service providers such as hospitals can only be achieved if information systems cater for the information needs of these various groups. They argue that the success of performance measurement systems in health care organisations depends greatly on “the information system infrastructure and the degree of integration between information systems used at various levels” (Ballantine et al., 1998:91).

Increasingly the relevance of accounting information for managers and other users will depend on whether or not it is related to the public managers’ work, which is focused on demands for greater accountability (Jonsson, 1998). However, what constitutes relevant information has become “ambiguous and uncertain, and that what is needed is for management accounting to realign with managerial work” (Jonsson, 1998:415). A challenge for public sector organisations is to move away from periodic out-of-date reports to a system of continuous reporting (Bellamy & Taylor, 1998) whilst also recognising that accounting controls “cannot be successfully imposed upon unwilling recipients” (Jones & Dewing, 1997:264). NPM reform has meant that senior

management are expected to achieve control of their organisations with the help of management accounting techniques (Brunsson & Sahlin-Andersson, 2000:727). This may mean that there is growing importance attached to the accounting function and the role of accountants and finance managers in public sector organisations. However, one implication of this is that accountants and those responsible for finances within an organisation can gain from having assessment criteria articulated in their language, which requires a technical knowledge to fully understand it (Guthrie et al., 1999).

The nature of accountancy dialogue has and continues to change to one where the emphasis is on efficiency, effectiveness and cost savings – managerialism in the public sector (Hood, 1991; Pollitt & Bouckaert, 2000). However, accounting change supporting changing demands for greater accountability is complex. Attempts to alter management accounting practices need to consider the influences that impinge on such efforts. Baxter & Chua (2003:108) argue that changes in management accounting practices emerge “as a highly situated phenomena – limited by historical conditions that are specific to given times and places; limited by local meanings and values; and limited by the local rationalities found in particular organisational settings”. Hence, the need to provide contextual information in chapter 4 (NPM implementation in Ireland) and chapter 6 (historical and social contextual background).

Issues of trust need to be considered in the implementation of NPM ideas and practices in large specialised public sector organisations. Persistent demands for greater evaluation of the performance of others is seen by some as a creeping distrust spreading through the public sector (Hoggett, 1996; Miller, 1996). Accounting is not an impartial technique (Miller, 1996). Accounting systems and know-how are part of the structure and use of power in organisations and society (Baxter & Chua, 2003). Consequently “the technologies of the accounting craft favour some organisational participants and disadvantage others” (Baxter & Chua, 2003:108). The presence, absence or erosion of trust as part of NPM reforms has not been adequately considered in studies to date, although Hood (1995a:174) did consider that what is being observed in NPM

implementation could be understood as a “a shift from a high-trust to low-trust” series of relationships in the public sector.

Hood (1995b:97) argues that “accountability involves more active control of public organisations by visible top managers wielding discretionary power”. This increased discretionary power is one of the facets of NPM that distinguish it from old style public administration where the emphasis was on hands-off management by relatively anonymous public servants. Greater discretion involves increased power, as the person exercising the discretion has the freedom to choose and implement from among alternatives. This aspect of NPM is of particular importance in public acute hospitals in Ireland. There has been an attempt here to implement NPM ideas in this sector where the influence of professional groups is strong. However, any attempt to secure greater control of public hospitals by managerial groups ultimately leads to a loss of power by other groups and to the possible emergence of negative issues concerning trust resulting from the perceived disempowerment. This trust dimension of NPM has not been addressed adequately in the NPM literature to date. This study contributes to an increased understanding of the role of trust in implementing NPM ideas in the Irish public acute hospital sector, a sector consisting of various professional groups and a management group increasingly attempting to exert greater managerial control.

3.7 Trust

Hood (1995b:98) noted that one “counter trend” that can sometimes be observed simultaneously with the introduction of NPM ideas is “the weakening of trust in professionals while strengthening the hand of managers”. Accounting has a role to play in the changing notion of accountability under NPM. Hood (1995b:94) considers accounting as reflecting “high trust in the market and private business methods and low trust in public servants and professionals..... whose activities needed to be more closely costed and evaluated by accounting techniques”. Thus the introduction of structural and managerial dimensions of NPM must consider issues of trust in public sector organisations. Similarly, Hogget (1996:23) argues that the formalisation of controls

such as those introduced under the mantle of NPM can be seen as “a solution to the absence of trust” in public sector organisational members.

Organizations are functionally differentiated to address the need to secure and utilize resources efficiently. A problem in large decentralised organisations is that when groups form, “the shared experiences of individuals and groups at a distance from their superiors” raises the possibility of the development and institutionalising of local interests which may be antagonistic to senior management (Roberts & Scapens, 1985:453). In addition, in these organisations high levels of technical differentiation create problems that “manifest as issues of control, co-ordination, conflict, commitment and legitimacy” (Blunsdon & Reed, 2003:14). Public hospitals are a key example of large specialised organisations (Pettersen, 2001). Those attempting to develop new forms of public sector management may have an uphill struggle within professional establishments such as hospitals (Maddock & Morgan, 1998). Increased accountability and performance management may not be perceived by organisational stakeholders as a neutral process. Many doctors consider performance management to be a “direct attack” on the medical profession (Maddock & Morgan, 1998:244). This can lead to a lack of trust in management, less than full participation in new organisational structures, and avoidance of organisational systems.

Yet it is well recognised that trust is a vital component of every interaction system (Blau, 1964; Simmel, 1967; Lane, 2000). Trust has to be earned and develops slowly over time (Gilbert & Tang, 1998). It is increasingly accepted as an important element in determining organisational success (Tyler & Kramer, 1996; Sako, 2000). Antecedents of trust include communication climate, job security, perceived organizational support and procedural justice (Carnevale & Wechsler, 1992; Albrecht & Travaglione, 2003). Procedural justice relates to the employees’ assessment of fair conduct and fair processes, both of which lead to development of a positive attitude towards management (Lind & Tyler, 1988; Albrecht & Travaglione, 2003). Trust is often perceived to be the “lubrication that makes it possible for organizations to work” (Bennis & Nanus, 1985)

and the source of increased efficiency and effectiveness (Zand, 1972; Culbert & Mc Donough, 1986). Structural and managerial changes in public sector organisations, under the NPM mantle since the early 1980's, have been directed at this same objective: improved performance for the same quantity of resources.

At the core of NPM is a new emphasis on the "importance of public managers' discretionary space or freedom to manage" (Hood, 2000:1). Increased involvement of clinicians in management has been encouraged in many countries in an attempt to better manage scarce resources (Abernethy & Stoelwinder, 1990; Jones & Dewing, 1997; Kurunmaki, 1999; Office for Health Management, 1999; Pettersen, 1999; Office for Health Management, 2002). However, without consideration of trust such attempts may not be fruitful. There may be opportunities "to improve public sector efficiency and effectiveness by improving levels of trust between public sector employees and senior management" (Nyhan, 2000:103; Albrecht & Travaglione, 2003:88). Trust can be enhanced by developing the quantity and/or quality of communication interactions over time (Blau, 1964). By linking trust to communication one can start to identify the means to build trust, even in situations where diverse partners are brought together (Hardy, Phillips, & Lawrence, 2000).

Increasing communication has been shown to enhance trust significantly in service-providing settings (Podsakoff, MacKenzie, & Bommer, 1996). Hospitals are a prime example of a complex service-providing setting. Kurunmaki (1999:221) argues that the worsening economic conditions of the 1980's and emerging stories of wastefulness "exacerbated" the "emerging distrust of medical professionals" in western societies. She notes that 'increased demands for accountability using accounting statements pertaining to delineated parts of the hospital organisation "did not fit the views of the medical professionals, who had a broader view of the basis of their accountability" (Kurunmaki, 1999:226). She concludes that "the apparent lack of a shared belief in accounting-based performance measures... has the potential to undermine attempts by health reformers to increase the symbolic power of hospital management" (Kurunmaki,

1999:234). However, in a UK study, Jones (1999) found that successful reform initiatives in acute hospitals were most likely where the presentation of proposals for refinement in clinical cost information coincided with both greater transparency of costings and increased attention to the cultural tensions between administrators and managers.

The absence of trust can have negative consequences for the performance of the organisation (Carnevale & Wechsler, 1992). One consequence of an absence of trust in an organizations includes a cynicism towards change (Andersson & Bateman, 1997; Laschinger, Finegan, Shamian, & Casier, 2000), as individuals who distrust the system tend to resist (Culbert & Mc Donough, 1986). NPM reforms involve both a structural and managerial dimension (see chapter 2, Table 2.1). It is this structural reorganization that is particularly “corrosive of trust in management” (Morgan & Zeffane, 2003:55). One way to minimise resistance is for senior management to trust. Trust by superiors increases the probability that employees have a right to greater information (Laschinger et al., 2000). Consequently, as they receive more information employees may trust more as they will be more adept at determining managements’ trustworthiness (Podsakoff et al., 1996). Therefore programmes for building trust need to address issues of communication (Young & Daniel, 2003:150).

Whilst trust is important in even the most minor and routine activities of organisational life, the concept of trust is anchored in perception (Webb, 1996). Webb identified crisis as an impetus for the development of trust. Crisis involves “the recognition of a threat and an assessment of resource adequacy to meet the said threat” (Webb, 1996:290). There is only a crisis if one believes that resources are not adequate to cope. Substantial uncertainty which is part of each crisis results in dependency on others (Webb, 1996). It is this dependence in a crisis situation which may result in the growth of trust with the resultant benefits outlined earlier in this chapter. In western democracies, the growing demands for health care are placing great strain on government finances. Advances in medical technology mean that new areas of medicine have also to be funded as well as

the traditional areas. Increasingly there are inadequate resources to meet the needs of those trying to access the system.¹³ If this budget restrictiveness is seen as being of crisis proportions, then it is possible that there may be a development of dependencies and the growth of trust in some public sector organisations.

Trust is dependent on “direct personal engagement with the other party in a collaborative process” (Dietz, 2004:16). In order to develop trust in public sector organisations there needs to be greater dialogue and communication between managers and professional groups. Empowerment is also important to understanding and developing trust in organisations (Culbert & Mc Donough, 1986). The trust based model advanced by (Nyhan, 2000:88) proposes “that increased participatory decision making practices, specifically empowerment, feedback, and collective management decisions will lead to increased trust and positive organisational outcomes”. Nyhan argues that the trust based model recognises the critical role of the worker as the primary deliverer of service in the public organisation. In public sector organisations such as hospitals, the workers who deliver the service are predominantly from professional groups. Culbert & McDonough (1986:182) warn that an individual will not internalise a system that is not “personally and professionally empowering to him/her”. Therefore, in implementing NPM reforms of a structural and managerial nature, consideration needs to be given to both the trust dimension of NPM and the differing cultural backgrounds of managers and professionals in complex public sector organisations such as hospitals.

3.7 Summary

The discussion in this chapter has centred on the increasing importance of the control element of the public sector management function. This increased emphasis on control

¹³Waiting list statistics of the Department of Health & Children show that numbers on public hospital lists waiting for in-patient or day-case treatment were 24,778 in 1994, 33,924 in 1999 and 27,318 at the end of December 2003 (the most recent statistics available in May 2005). In 2004 the Minister for Health & Children transferred responsibility for recording and publishing of numbers waiting for treatment as public patients in Irish acute hospitals from the Department to the National Treatment Purchase Fund. In May 2004 the Fund reported that waiting list figures at 31st December 2003 were overstated by approximately 4,500.

has led to growing concerns about accountability. There is a tension between two forms of accountability, public accountability and managerial accountability, each of these reflecting different core values. It was argued that managerial forms of accountability have eroded democratic accountability concerns such as equity, effectiveness of outcomes, social justice, legality, legitimacy and probity. Choosing to highlight either form of accountability is a reflection of social democratic concerns at government and societal level in any country.

The importance and necessity of performance measurement to discharge both forms of accountability was discussed together with an outline of the difficulties experienced in doing so. The expanding role of accounting and growth of accounting techniques and practices, beyond the mere supply of financial information for decision-making, has been examined. A prerequisite for implementing NPM ideas is an organisational control system that is capable of producing information to support changing modes of management control. NPM involves a change in management approaches to organisational control. At the core of this study is whether accounting control systems in the four acute hospitals are changing and developing to support the changing management approach.

The non-neutral nature of accounting systems, and developments to these systems, can affect the influence of various groups in organisations. Large decentralised organisations, such as public acute hospitals, are staffed by groups with varying degrees of autonomy and influence. Such groups are affected by and aware of changes to organisational control systems. Their perception of changes can influence levels of organisational trust, which has consequences for the performance and working of the organisation. Trust is an important element of every organisation and interaction system. Communication is one of the antecedents of organisational trust. Managers of large decentralised organisations have at their disposal a means of increasing trust – increasing the quantity and quality of communications with organisational members. A failure to develop and maintain trust in an organisational context results in a cynicism

towards change. The introduction of NPM ideas and practices requires change in public sector organisations. Overlooking the necessity to consider trust may militate against successful implementation of NPM ideas in these organisations to bring about desired organisational outcomes. Before exploring and explaining both NPM intentions and the reality of implementation efforts in the case study chapters (chapters 7-10), evidence of the development of NPM in Ireland is discussed (see chapter 4). The need for a knowledge of the historical and societal context as a background to understanding attempts to implement NPM reforms has been referred to in this chapter and is provided in chapter 6. This follows a discussion of research methodology (see chapter 5).

CHAPTER 4

THE INSTITUTIONAL BACKGROUND: NPM IMPLEMENTATION IN IRELAND

4.1 Introduction

Public sector management and organization cannot be fully divorced from its social and political context (Hood, 1974; Kickert, 1997). Whilst NPM is a global phenomenon (Olson et al., 1998; Pollitt & Bouckaert, 2000), previous studies have not included a review of public sector reforms in Ireland. However, there are now many of the dimensions of NPM evident in Irish public services. Hood (1995a:169) argues that the “indiscriminate export of hand-me-down public management ideas may stifle appropriate variety in public sector policy response”. Hence the need to examine NPM reforms in their historical and organisational context, the approach adopted in this study.

The Irish government appeared to accept the need for an overhaul of public sector management as evidenced in their commissioning of public sector review groups and White Papers.¹⁴ The Irish story is one of reluctance over many years to modify public service management as recommended by both government commissioned reviews and White Papers (Brennan Commission, 1935; Devlin, 1969; Irish Government, 1985). There is evidence of NPM in some of these documents (e.g. the need for “management systems based on corporate planning and emphasizing personal responsibility for results, costs and service” (Irish Government, 1985:6). However, this is only evidence of the language of NPM. Government institutional and organizational structures remained predominantly the same from the foundation of the State in 1922 until 1997 when the Public Service Management Act was passed. In this chapter, the institutional background and the distinctive terminology used in Ireland to describe the various parts of the public sector are explained. These factors are important elements with regard to the manner and timing of the emergence of NPM in Ireland.

¹⁴ The purpose of a White Paper is to indicate Government thinking on policy and to provide the public with an opportunity to comment on it (Dail Eireann Debates, 1996).

4.2 The Context of Irish Change¹⁵

The Oireachtas is the National Parliament of Ireland and consists of the President and two Houses, namely Dail Eireann (Lower House) and Seanad Eireann (Upper House). The Dail is the house of representatives and is elected by popular vote. The Seanad is mainly elected by a very limited franchise and is partly nominated. The government is responsible to the Dail. The Ministers and Secretaries Act 1924, created the minister as the ‘corporation sole’ of each government department. The legal personality is the minister and the department is an extension of that personality. This was an attempt to ensure that the minister would be fully accountable to the Dail for the performance of that department (Dooney & O’Toole, 1998). To this day this remains the legal foundation of the centralization of Irish government. The government appoints the civil service. There are two broad functions that the civil service performs: the delivery of a wide range of services to the public, and the formulation of policy. Before proceeding further with this discussion it is necessary to define the terms civil service, public service and public sector. These are used interchangeably by many writers in Ireland, but in a manner different from other commentators on public sector reforms. Table 4.1 outlines the various definitions used in this chapter, and all of the subsequent analysis and discussion refers to the public service unless specified otherwise.

Table 4.1: Civil Service, Public Service and Public Sector Definitions

Civil Service	Government Departments + Offices of the State
Public Service	Civil service + health services, teachers and other staff in the education area, staff in local authorities, staff in the non-commercial state-sponsored bodies e.g. health boards, Teagasc, Legal Aid Board
Public Sector	Public service + staff in the commercial state-sponsored bodies e.g. Electricity Supply Board, Voluntary Health Insurance

Source: (Irish Government, 1985)

¹⁵ Management change in the public sector cannot be fully understood unless interpreted as part of the pattern of political issues concerning a country, and the responses or lack of responses to these (Tutty, 1997; Pollitt & Bouckaert, 2000).

Note that the public service includes the regional health boards, responsible for the management and delivery of health services in each region until 31st December 2004, when this responsibility passed to the newly formed Health Service Executive.¹⁶

The civil service is concerned primarily with legality and equality of treatment (Irish Government, 1985). However, an over-concentration on these issues can lead to a lack of concern with the speed and cost of delivery of services. Barrington (1980) cites the Irish civil service in the early 1980's as being preoccupied with the performance of day-to-day operations and having a lack of concern for the performance of the system as a whole. In Ireland, the structure of the civil service consists of a strong vertical organization divided into separate departments and agencies, with comparatively weak horizontal structures (Humphreys, 1998:47). The work of individual departments tends to be determined by sectoral and functional demands (Tutty, 1997). The public service in Ireland makes up a significant proportion of total economic activity. Its performance, therefore, has significant implications on the efficiency and competitiveness of the Irish economy. Indeed, with the development of the global economy, for most countries the public sector has become a critical focus of governments' attempts to increase efficiency (see chapter 2).

While there is evidence of significant change in the Irish public service over the past twelve years, there were many who realized that improvements in its performance could have been made many years ago (Devlin, 1969; Chapman, 1975; Whelan, 1975, 1977; Murray, 1982). This chapter examines the slowly emerging pattern of change by considering the reviews of, and reports on, the structures and operation of the Irish public service over time (section 4.3). This story of reluctance to undertake reforms, following reviews of the workings of the public service (outlined in section 4.3), is followed by an examination of the emergence and codification of NPM in Ireland (section 4.4). The chapter then provides a brief critique of other significant events (in section 4.5) that contributed, to the fact that only minor changes were made in the period

¹⁶ Further information on the Health Service Executive is provided in chapter 6.

to the early 1990's and, to the unprecedented scale of change in the Irish public sector that has subsequently taken place over the last twelve years. The substance of Irish NPM is then examined (section 4.6) followed by a summary of the chapter (section 6.8).

4.3 Reform Efforts from Independence in 1922 to the end of the 1970's

The Brennan Commission on the Civil Service (1932-35) was the first body established to examine the working of the Irish civil service since the foundation of the State in 1922 (Brennan Commission, 1935). The second review – The Devlin Commission 1966-1969 – followed over thirty years later, inspired by recognition in The White Paper on Economic Development 1958 that in order to encourage national economic prosperity, the structure and working of the public service needed to be re-examined. Each of these three documents is reviewed below.

4.3.1 Brennan Commission Report 1932-35

It had narrow terms of reference:

to inquire into and report on the recruitment and organization of the civil service with special reference to ensuring efficiency in working,....accepting that the established position is the starting point, and that its subsequent directions must be determined chiefly by the extent to which we have definite evidence of shortcomings

(Brennan Commission, 1935:15)

The report states that “we accept the position as we find it and proceed to investigate on this basis how the civil service fulfils its part in the execution of the task of administration” (Brennan Commission, 1935:59). It describes that “it found the civil service in a highly organized condition and that it had been offered no evidence from any section of the community expressing any need for reorganization” (Whelan, 1975:107). This, the earliest review of the workings of the Irish civil service, had a limited remit and showed reluctance and hesitancy from the beginning in approaching public sector administrative reform.

4.3.2 White Paper on Economic Development 1958

The White Paper on Economic Development in 1958 marked the formal recognition of the notion of direct state responsibility for economic (and later, social) planning

(Stapleton, 1991). From this followed a shift in the role of the public service in the direction of development administration. It was recognized in the White Paper that the ordinary processes of the civil service would not be adequate to the task of development (Irish Government, 1958). There was an acceptance that modern governments are concerned with creating the conditions in which the economy could expand and that the public service needed an overhaul (O'Donnell, 1979). It was in this climate that the Public Services Review Group was established in 1966 with terms of reference "to examine and report on the organization of departments of State at the higher levels" (Devlin, 1969:3). This is the first evidence of the emergence of a number of NPM concepts.

4.3.3 The Devlin Commission 1966-1969

The initiative for the Devlin enquiry came from the civil service, specifically from the senior staff in the Department of Finance (Murray, 1982). The review group consisted of people with wide experience of the public service and private business. Unlike The Brennan Report in 1935, the Devlin Report identified the role of the public service as two-fold: the formulation of policy involving an advisory service to government in the formulation and review of policy, and quite separately the execution of settled policy by means of the detailed management of executive functions in government departments. The report concluded that the faults with the civil service were largely institutional while personnel defects, although serious, were considered to be of secondary importance (Devlin, 1969). It recommended that the doctrine of 'ministerial responsibility' be radically restricted to the areas of broad policy, and that policy execution and responsibility should rest with civil servants in Executive Units (the 'Aireacht' concept).

Other recommendations (Devlin, 1969) included the setting up of a Department of Public Service (subsequently established in 1973 and abolished in 1988), the creation of a Commissioner for Administrative Justice to set up and oversee an appellate system in the public service (this resulted in the Ombudsman Act of 1980, with the first Ombudsman being appointed in 1984) and the promotion of every post, at or above

assistant principal level, on the basis of merit. Overall, Devlin (1969) argued that the apex of the public service administrative system was over-burdened. The then Minister of Finance, when asked what action he intended to take on the Report, replied “This is one of the most important documents that has come before government and Parliament for a long time and the suggestions put forward by the Devlin Commission are very far-reaching and fundamental” (Dail Eireann Debates, 1969: volume 242). However, few of the recommendations of the Devlin report were implemented, providing yet further evidence of the ‘reluctance to engage’ with the reform process. A public service reform programme was initiated in 1973 when an attempt was made to separate the policy development and execution functions on an experimental basis in five government departments (Stapleton, 1991). Progress in applying the ‘Aireacht’ concept proved extremely slow.

A number of explanations have been suggested for the lack of progress with civil service reform. These include impending European Economic Community membership, worsening economic conditions, the emerging Northern Ireland problem, the employment background of most of the senior staff in the new Department of the Public Service, the transfer of matters relating to pay to the new department, lack of political will and lack of pressure for reform from within the civil service itself (Whelan, 1975; Stapleton, 1991). This lack of political will is explained in more detail below.

4.3.4 Explanation for Lack of Public Service Reform 1922 – late 1970’s

There was little political or administrative support for pushing responsibility for executive activity into the civil service structure and limiting ministerial responsibility (Murray, 1982). Key recommendations of the two main reviews and reports on the public sector, The Devlin Report 1969 (Devlin, 1969) and The 1985 White Paper (Irish Government, 1985), had dwelt in detail on the two functions that civil servants are expected to execute: firstly, the policy advisory function to ministers, and secondly the implementation of agreed government policy in respect of their functional area. Both reports recommended a separation of these roles. However, the Ministers and

Secretaries Act 1924 required that the minister be fully accountable to the Dail (Parliament) for the performance of his/her department. It was widely believed that many members of the Dail (members of Parliament) valued the opportunity presented by parliamentary question time to question government ministers on matters relating to that minister's department and the members' own constituency (Chapman, 1975). Robinson (1974:9) noted that "it is more important for the advancement of his (the Dail Deputy's) political career to get medical cards, agricultural grants, etc. than to research a particular legislative proposal or to examine governmental activity in detail".

The result of the organizational structures was a very "localized" level of discussion in the Dail (Chapman, 1975). Much of the Irish government's reluctance to undertake significant reform of management of the public service centred on the unwillingness to alter the position of the minister as 'corporation sole' of a department. What tended to happen in departments, right up to the Secretary, was that execution completely overshadowed policy formulation (O'Donnell, 1979:41). The implication of this responsibility resulted in ministers' involvement in relatively minor decisions in government departments. The emphasis on ministerial accountability also meant that government departments were very hierarchical and that ministers' political needs often dominated any 'managerial issues'.

In 1976, the then Deputy Secretary of the Department of the Public Service stated that there had been no reform of the public service and that "the basic structure of the public service was as it had been at the foundation of the State despite the development of an increasingly complex socio-economic environment" (Whelan, 1977:4). Whelan also noted the urgent necessity for reforms, which would free ministers and their advisors from the pressures of day-to-day executive decisions so that they might be enabled to concentrate on policy formulation, legislation and planning. This perspective recognized the political reality that reform of public institutions only takes place when supported by political commitment from, and at the pace allowed by, the executive government. Others agreed that this lack of political commitment to reform by

politicians and civil servants was the primary cause of the failure to implement Devlin's proposals (Murray, 1982). However the debate and discussion that took place following the publication of The Devlin Report and the lack of progress with its implementation in the 1970's may have served to provide some impetus for action on public service reform when the debate was reopened in the early 1990's. This historical review of the reluctance to engage in significant public sector reform is an important antecedent of public sector reforms that took place subsequently.

4.4 Emergence of NPM

A Fianna Fail majority government returned to power in 1977, equipped with a program of planned expansion, including a deliberate policy of job creation in the public sector. This trend, however, was halted on the return to government of a minority Fine Gael-led coalition government in 1982. There then followed a period of retrenchment and a partial embargo on recruitment in the public sector (Stapleton, 1991). Staffing economies in the civil service and the wider public service in the early 1980's were achieved by means of an embargo, which permitted the filling of only two vacancies in every three. Civil service numbers were reduced by 8.5% as a result of this measure (Irish Government, 1981).

Throughout the 1980's, there is evidence of several NPM concepts slowly emerging in the Irish context with the introduction of certain financial management techniques, the Executive Unit ('Aireacht') concept in many departments (intended to facilitate a division between the policy formulation and policy execution functions), and also increased powers for the Comptroller and Auditor General. The 1981 White Paper was a landmark that in turn led to the establishment of the Dail Committee on Public Expenditure and the publication of Comprehensive Public Expenditure Programs by the Department of Finance (Irish Government, 1981). The purpose of this publication was to enable the Dail to know the total costs associated with each area of policy activity (rather than just the cost of each department), and with the aid of measures of output and performance provided, to assess the value of each program (Irish Government, 1981).

The financial management initiatives introduced in the period 1980-84 by the Department of Finance, however, ended up representing little more than a “traditional strengthening of departmental ascendancy in a time of fiscal stringency” (Dunne, 1989:8). Here again was evidence of modest steps towards incorporation of some of the principles of new public management (e.g. value for money, measures of output, performance measurement and service costs) into Irish public service management practices.

By 1982, the Executive Unit Concept (‘Aireacht’) recommended in The Devlin Report had been introduced into most government departments on a trial basis.¹⁷ In reviewing progress on ‘Aireacht’, a former Secretary of the Department of Finance and civil servant of forty years noted that, despite the appearances of reform, there was little substance to the changes (Murray, 1982). A failure to recognize and accept the importance of the separation of the functions of the minister may have lain at the root of the lack of commitment to instigate real change (Murray, 1982). An unwillingness to loosen the grip on the reins of power may also be part of the explanation for retention of the status quo. Elected politicians displaying concern for voters from their local constituencies in the Dail were securing votes for the next election. Proposed reforms in The Devlin Report required politicians to reduce their involvement in the operational management of their departments, which in turn could result in less awareness of local issues and ultimately less time to influence outcomes positively leading to a perceived loss of power at local constituency level.

4.4.1 The 1985 White Paper on the Public Service

A change in government in 1982 brought with it the next attempt to reform public service management, effectively seven political administrations after the publication of the Devlin report.¹⁸ The 1982-87 Fine Gael/Labour government was interested in

¹⁷ The purpose of this Executive Unit Concept (‘Aireacht’) was a restructuring of government departments to allow a trial separation of the policy formulation role of ministers and the separate execution of this policy by civil servants.

¹⁸ See Appendix B for an outline of governmental administrations during the 1970’s and 1980’s.

developing a generalized management model for the civil service (Stapleton, 1991). This government, more than any other government in the history of the State, attempted to tackle the issue of institutional reform ‘properly’ (Dunne, 1989:1). The new government, in December 1982, institutionalized a commitment to administrative reform by appointing a minister with sole responsibility for the public service. A review of the public service was undertaken, resulting in the publication in 1985 of the government White Paper ‘Serving the Country Better’ (Irish Government, 1985). This report set out a program of management improvement based on the concept of managing for results and recommended a major development of the public service. A brief recount of the history of the emergence of this White Paper is essential to an understanding of Ireland as a reluctant reformer.

The Minister for the Public Service indicated in a public speech in December 1984 that the White Paper would soon be issued (Dunne, 1989:9). He stated that the position whereby each government minister was responsible for every decision taken in his/her department needed to change to allow for clearly defined responsibility and accountability in the civil service. This conflicted with the executive government position in the subsequently published 1985 White Paper, which stated “it is clear and indeed it is central to our form of democracy, that ministers *must remain* responsible for all aspects of the business of their department and must answer to the Dail for them” (Irish Government, 1985:25). The debate on this issue of ‘ministerial responsibility’ may explain the delay in publishing the report – the White Paper was not published until autumn 1985.

This, the second comprehensive review of the public service since the foundation of the State, examined the issue of the position of ministers of government departments and their relationship with civil servants.¹⁹ Yet the challenge to alter the position of the

¹⁹ The first comprehensive review being The Devlin Report 1966-1969. The Brennan Report is not recognised as a ‘change’ report (although its remit and terms of reference were a review of the working of government) given that, on the whole, it recommended maintenance of the status quo.

minister enshrined in the Ministers and Secretaries Act of 1924 was not taken up. This meant that only minor reform of the public service was possible, further evidence of reluctance of successive governments to implement significant public sector management reform. The 1985 White Paper (like the Devlin Report, 1969) stated that in most departments there was no clear or satisfactory separation between the policy advisory functions and the day-to-day management of executive activities. It recommended that all government departments should introduce management systems based on personal responsibility for results and value for money before the end of 1985. Here again there are clear indications of the components of NPM: effective and efficient service, responsibility for results, and value for money. The report was critical of the then current practice of monitoring activities rather than results (Irish Government, 1985). A new Fianna Fail government in 1987, faced with worsening economic conditions, adopted a budget that contained restrictive measures in relation to both numbers and pay of public servants. The deteriorating economic situation may have been the impetus needed for all the social partners to reach a consensus on an overall plan for economic recovery, which in turn contributed to the emergence of NPM.

4.4.2 The 1990's: the Emergence of NPM – the Strategic Management Initiative

In 1994 at a meeting of ministers and secretaries of government departments, the Taoiseach (Irish Prime Minister) declared his determination to give the public service a new strategic focus. This became known as the Strategic Management Initiative (SMI) for the public service (Boyle, 1995). A new tri-party coalition government of Fine Gael, the Labour Party and Democratic Left was established in December 1994. In its statement of policy, the government pledged itself to a reform of institutions at national and local level with the intention of improving accountability and transparency and freedom of information (Fine Gael, The Labour Party, & Democratic Left, 1994). There was, therefore, clear cross-party political support for the public administration reform process. From within the civil service there was also a desire for change. A report compiled by a group of assistant secretaries pursuing a Masters Program in Public Sector

Strategic Management indicated the need for a process of reform in the civil service (M.Sc. Class of Assistant Secretaries 1993/94, 1994).

The Irish government subsequently requested senior civil servants to conduct a review of existing systems for making decisions, allocating responsibility, and ensuring accountability and to bring forward proposals for improvement in the performance of the civil service. The government approved and adopted the framework outlined in the report of the Coordinating Group of Government Secretaries on proposals for an integrated program to modernize systems and practices (Coordinating Group of Government Secretaries, 1996). The initial impetus for regulatory reform can be traced to this seminal document. This report became the Irish government's new public management policy document for reform of the public service.

This report, *Delivering Better Government*, provided the detail to support the process of modernization and change encapsulated in the term Strategic Management Initiative, initiated two years earlier (Coordinating Group of Government Secretaries, 1996). The report set the overall agenda for the civil service as a whole and was directed at the stated twin goals of *better government* (in terms of better quality regulation, greater openness/transparency and more effective management of major national issues), and *improved delivery* through ongoing improvements in service performance and a clearer focus on achieving objectives (Coordinating Group of Government Secretaries, 1996). This initiative effectively formalized what was already an emerging reform process within the civil service. One of the central tenets of the SMI was the devolution of accountability with appropriate responsibility from the centre to executive agencies (Butler, 2000).

The 1996 policy document *Delivering Better Government*, together with sectoral strategies in education and health, set the strategic direction for the Public Service and the essential principles governing the required changes. *Delivering Better Government* identified the main areas for change as: delivering quality service to customers; reducing

red tape; delegation of authority and accountability; improved human resource management; improved financial management and ensuring value for money; use of information technology; and improved coordination between departments. In this 1996 report, one can see many components of NPM (Coordinating Group of Government Secretaries, 1996). The central thrust was the desire for an excellent service for government and for the public as customers and clients at all levels. The recommendations related initially to modernization of the civil service, but recommended a widening of the SMI process to all public service bodies within twelve months. By the mid-1990's, there was support for a change in public administration from both the political and administrative stakeholders. Since then, the Irish civil and public service has undergone a process of modernization.

This process must be understood in the context of socio-economic and political forces (Pollitt & Bouckaert, 2000).²⁰ It has mainly been pursued under the banner of the SMI but it has also been embedded through the concept of partnership at national and organizational level (Doyle, 2000). The strength of the SMI process rests in the location of the SMI unit in the Department of the Taoiseach and the role of the cross-departmental coordinating group of nine government secretaries. Their function is to facilitate the process; evaluate strategy statements; recommend how interacting strategies can be coordinated; recommend changes to enable more efficient and effective management of the civil service; and to report to the government (Dooney & O'Toole, 1998). What is unusual about the case of public sector management reform in Ireland is that the reforms have been supported by detailed legislative changes. The coalescing of economic and social pressures led to the Irish government giving NPM a new significance, namely through its codification in statute as 'best management practice'.

²⁰ At this time Irish political life was convulsed by a series of scandals that raised questions about the nature of the relationship between civil servants and ministers. See Report of the Tribunal of Inquiry into the Beef Processing Industry (1994), Report of the Tribunal of Inquiry – Dunne Payments (1997) and Report of the Tribunal of Inquiry into the Blood Transfusion Service Board (1997). These controversial, highly publicized and emotive developments placed the issue of open government at the heart of the public service reform process.

4.4.3 Codification of NPM in Irish Law

Unlike many other jurisdictions, the Irish government has enshrined the principles of NPM in legislation in the form of the Public Service Management Act, 1997 (PSMA, 1997). On this occasion the structural changes necessary to support the reform of the public sector were facilitated by legislation dealing with the issue of government ministers and 'corporation sole' in the Ministers and Secretaries Act, 1924. The position of the minister had not changed but the responsibilities and accountability of civil servants had been altered significantly with the PSMA 1997 (sections 4 and 9). While Ireland may have been reluctant to pursue significant public sector management reform for many decades, it subsequently sought to ensure that the changes it promoted would be embedded for the future through their codification in statute. The governance changes that were initiated through legislation in the mid-1990's facilitated a move from a highly centralized control of human and financial resources to one of greater decentralization and devolution of authority and responsibility, based on new accountability frameworks. Reluctance to reform was replaced by a commitment to change. The trajectory of reform was prolonged, with intense debate over decades without any significant reform, which ultimately led to an abrupt, prescriptive adoption of NPM by statute: the PMSA 1997. It was with this Act that Ireland started to lose the tag of 'reluctant' NPM reformer.

With the enactment of the PSMA 1997 the minister remains responsible for the performance of functions that are assigned to the department (section 3). However, section four of the PMSA 1997 specifically addressed the issue of responsibility and accountability of the Secretary General of a government department for specific tasks, including: management of the department, preparation and submission of a strategy statement, assignment of staff responsibilities, "delivery of outputs as determined with the Minister of the Government having charge of the department". The PMSA 1997 is of particular significance in that it established a formal structure for the management of the civil service by setting out, in legislation, the functions and responsibilities of Departmental Secretary Generals and Heads of Offices. It enabled them to delegate

formally some of their functions to other grades within their departments and offices – for the first time since the foundation of the State. This meant that individual civil servants could be held legally accountable in a way that had not previously been the case. Many components of NPM as identified in Hood (1991; 1995b) are evident in the Act – as Table 4.2 illustrates.

Table 4.2: Codification by Statute of Elements of NPM

Hood (1991; 1995b)	Public Service Management Act, 1997
Doctrinal components of new public management:	
a) hands-on professional management	Sec. 4.1 ... "Secretary General of a Department ...have authority, responsibility and accountability"
b) explicit standards and measures of performance	Sec. 4.1 (a) "monitoring Government policies" Sec. 5.1 (a) "a strategy statement shall comprise key objectives, outputs and related strategies (including use of resources) of the Department"
c) greater emphasis on output controls	Sec. 4.1 (a) "delivering outputs" Sec. 4.1 (c) "responsibilities to be assigned" Sec. 9.1 (b) "an officer of a Department...shall achieve the outputs specified...assume responsibility for delivering quality services,... ensure expenditure made accords with the purpose for which the expenditure was chargeable...and that value for money is obtained"
d) greater competition in the public sector	-----
e) shift to disaggregation of units in the public sector	Sec. 4.1 (i) "assigning responsibility for the performance of functions ...to others ... to ensure the coherence of policy across the Department"
f) emphasis on private sector styles of management practice	Sec. 4.1 (b) "prepare and submit a strategy statement...3 year period"... "progress reports to the minister" Sec. 5.1 "a strategy statement shall comprise...key objectives, outputs...use of resources...be laid before each House of the Oireachtas" (Parliament)
g) emphasis on discipline in resource use	Sec. 4.1 (g) "developing means that will improve the provision...of cost effective public services"

The PMSA 1997 provides for the assignment of responsibility for cross-departmental issues in a structured and formal way, addressing an observed weakness of the Irish civil service, as noted by Coordinating Group of Government Secretaries (1996), Tutty (1997), and Humphreys (1998). The PMSA 1997 also changed the conditions of employment of many civil servants. Where before civil servants could only be removed from office by government, the PMSA 1997 gave responsibility for the appointment, performance, discipline and dismissal of civil servants to the Secretary General of a department. Table 4.3 sets out other legislation in support of these NPM developments.

Table 4.3: Other legislation helping to embed NPM in the Irish Public Service

<p>The Comptroller and Auditor General (Amendment) Act, 1993</p> <p>-introduced a statutory requirement on departments to be accountable for the effectiveness and value for money of their operations.</p>
<p>The Ethics in Public Office Act, 1995</p> <p>- implemented new structures intended to minimise the risk of conflicts of interest for those in public service, and to ensure greater transparency in decision-making. It provides disclosure requirements for significant decision makers in a wide range of public bodies, to ensure that decisions are not influenced inappropriately by any outside interests of these decision makers.</p>
<p>The Freedom of Information Act, 1997</p> <p>- a key element of the public service reform program, promoting accountability. It is “providing information and reasons for decisions, moving Irish administration away from the need of endless tribunals and investigations...and it is adding strength to the three pillars of transparency, accountability and service on which the Public Service of the new millennium is being built” (An Taoiseach, 1999). It offers a new and powerful watchdog role for parliamentary committees supported by extensive access to official papers and powers to summon officials and ministers.</p>
<p>The Committees of the Houses of The Oireachtas (Compellability, Privileges and Immunities of Witnesses) Act, 1997</p> <p>- part of a family of legislation which represents an improvement in the transparency of the process of governance and in the accountability of office holders and public servants. It requires not only personal attendance before Oireachtas appointed Committees but directs that such a person is required to give evidence and furnish any documentation requested by the committee.</p>

There has, therefore, been a series of developments, each adding to and reinforcing the others, on a continuum of measures to strengthen the overall system of accountability

and to make the workings of the public service more transparent and answerable to the Dail and citizens. The government's declared concern has been with the efficient and effective use of resources by a growing public sector. In contrast, the public's concern has been for transparency, openness, accountability and concern with value for money.

4.5 Socio-economic and Institutional Context - the Partnership Approach

A key element in the Irish government's strategy to implement NPM type administrative reforms has been its emphasis on partnership, in which it continues to draw on NPM principles. The partnership process was to be the force that drove the implementation of public sector management reform and NPFM in Ireland in the future. The Parties to the sixth National Agreement, Sustaining Progress, included the government, employers, trade unions, farmers, and the community and voluntary sector (Irish Government, 2003). Sustaining Progress set the agenda for the modernization of the civil and public service over the period 2003 - 2005. The partnership process was intended to spread throughout the public sector. A key element in administering SMI was to ensure that this was not a top-down or a line-by-line departmental process. Criticisms of previous attempts at reform have centred on the lack of inclusion of public servants in the reform process and the top-down approach adopted. In implementing the SMI, individual departments and offices drew up statements of strategy, setting out key goals and objectives and the means to achieve them (Murray, 1999). Of course drawing up these statements of strategy was a legislative requirement under the PMSA 1997 (section 5). But rather than leaving this as a top level exercise, a wide range of participative and coordinating groups were established, involving front-line staff as well as many middle and senior managers.

4.6 Assessing the Content of the Irish NPM – the Strategic Management Initiative (SMI)

The stated central thrust of the 1996 report Delivering Better Government (DBG), which sought to provide the operational detail of the SMI and which resonates with the traditionally declared ideas of NPM, was the achievement of an excellent service for government and for the public as customers and clients at all levels (Coordinating Group

of Government Secretaries, 1996). NPM in Ireland through the SMI process has been devised as an ongoing activity. It did not end with the DBG report or the passing of the PMSA 1997. Six core themes within SMI/DBG can be identified – in the form of openness, transparency and accountability, quality customer service, regulatory reform, human resource management, financial management and information systems. Improvements and developments in the first three areas were to be underpinned by organizational improvements in the latter three areas. Various initiatives (e.g. customer quality issues, management structures, financial management, cross departmental cooperation, devolution of authority, human resource management, regulatory reforms) which underpin the SMI are currently at different stages of development and implementation across government departments, but effectively constitute the implementation of NPM in Ireland. The human resource management programme is PPARS – a new Personnel, Payroll and Related Systems initiative. Its objective is to use information and communications technology to support the provision and development of human resource management in the Irish health service. Accounting and finance are important components of this development, but do not have primacy. The Irish interpretation of NPM has a strong emphasis on what constitutes good management practice as its overriding concern. In July 2001 a consulting group was commissioned by the Department of the Taoiseach to review progress achieved under the SMI/DBG program. They found that “the civil service in 2002 is a more effective organization than it was a decade ago. Much of this change can be attributed to SMI/DBG” (PA Consulting Group, 2002:4). An account of developments under each theme is outside the remit of this study. However, the development of financial management systems is outlined below.

4.6.1 Financial Management Systems

The Management Information Framework (MIF) is the new label given to the ‘generic model’ of financial management and has been recognized as having its roots in the recommendations of the DBG report, (see Implementation Group on the Strategic Management Initiative, 2001). Professional accountants have been recruited in many

departments to deliver the new financial management system by 2005. It is intended that the MIF will integrate with the Performance Management Development System (PMDS) and the strategy statement/business planning process and “will help to identify and measure outcomes” (Implementation Group on the Strategic Management Initiative, 2001:11). A key objective of the PMDS is to clarify the roles and responsibilities of staff and to give them greater understanding and control over their own work (An Taoiseach, 2000). The purpose of the MIF is to improve public sector financial management by introducing best practices to departments, comparable to those in industry and commerce, using accrual accounting (Department of Finance, 2002:13). Since the mid-1990’s, greater delegation of responsibility for, and control over, expenditure management has been given to line departments under the Administrative Budgets Initiative. Under this system, participating departments and offices negotiate administrative budgets with the Department of Finance in advance for a three-year period (Department of Finance, 2002). Greater freedom is accorded to departments in the way in which administrative resources can be used. A review report found that “administrative budgets are ... working well in the majority of government departments” (PA Consulting Group, 2002:69). However, this report also found that relatively little financial commentary is presented in statements of strategy and this might suggest that “resource allocation and prioritization are not necessarily regarded as a first step in the identification and selection of available strategic alternatives” (PA Consulting Group, 2002:69).

The statements of strategy of a sample of government departments show a variation in the specificity of performance indicators. Some departments very clearly link objectives for individual department responsibilities to strategies, outputs and detailed performance indicators (Department of Defence, 2003). Other departments provide detailed objectives without identifying detailed strategies to achieve these or performance indicators that might be used to measure achievement of objectives. Where performance indicators are identified, they are primarily non-financial measures which link output to departmental strategic objectives (Department of Defence, 2003). Other elements of the

MIF include the development of costing systems and the implementation of accrual accounting across government departments. A primary objective of the MIF is to develop reporting structures which create a link between departmental objectives, resources consumed and outcomes achieved. Government departments are allowed to exercise discretion regarding the extent of use of accrual accounting for this purpose. However, the annual accounts of the Irish regional health boards have been prepared on an accruals basis for the past thirteen years.²¹

4.7 Summary

The foregoing analysis and review of public administration reforms since the foundation of the State of Ireland in 1922 indicates that despite several studies reviewing the workings of the public service, little changed in the structure and operation of the Irish public service until the mid-1990's. There was an apparent persistent reluctance on the part of elected representatives to follow through with the recommendations of various initiatives that had sought reform of public sector administration. There was also no convergence of thinking between bureaucrats and politicians in the Irish government. From the mid-1980's, a desire for change was evident from within the administrative ranks of the civil service and also from within government. From 1995 there have been several significant attempts to ensure that reform succeeded. This is in contrast to the relatively indifferent reaction by governments to earlier reports on public sector administrative reforms. Senior civil servants came together and in 1996 produced the key policy document *Delivering Better Government* that was adopted by government to support the SMI announced two years earlier. It contained an approach to public service management that was felt to be more effective and viable than then current practices.

NPM has now arrived in Ireland, with significant change occurring in a relatively short space of time. The concept of reform has been based more on New Public Management than on New Public Financial Management. There has been a replacement of highly centralized structures with decentralized management environments. There is also a

²¹ Interview transcript, Assistant Principal, DoH&C.

closer focus on results. Legislation supporting the reform process has been enacted and partnership committees have been established to progress NPM ideas within and beyond the civil service. Ireland has been a reluctant reformer which came relatively late to the reform process, but has gone further in a relatively shorter period than other countries (Olson et al., 1998; Pollitt & Bouckaert, 2000).

The significance of the statutory codification of NPM has been profound. There was the occasional change in public sector management following publication of the 1985 White Paper *Serving the Country Better* (Irish Government, 1985). However, the structural changes necessary to allow greater responsibility and accountability of public service managers only came about with the enactment of the PSMA 1997. This not only changed the accountability of civil servants but also stipulated certain outputs and changed the nature of civil servants' employment. There is currently significant public administrative reform underway. NPM ideas are embedded in the Irish public service system and reforms have spread out across the public service. The most recent national social partnership agreement, *Sustaining Progress 2003-2005*, contains a chapter *Delivering Quality Public Services* which provides a framework for the continued modernization of the civil service, health, education and local government sectors through the implementation of a wide range of initiatives based around the principles of flexibility, increased value for taxpayers money and improved customer service (Irish Government, 2003:96).

The energies of civil servants who sought these reforms are being directed at the reform process through partnership committees and implementation groups within the civil service. The partnership groups, consisting of union and employee representatives in the public sector, are in place and are working towards a more cooperative approach to organizational change. This has established a momentum that has been absent in any previous attempt at public sector management reform. Legislation now exists which requires certain outputs. The PMSA 1997, for example, requires ongoing results from civil servants in the form of strategy statements (every three years) detailing outputs and

required resources to achieve such outputs. Government departments are not only preparing these statements, but are also producing interim reports detailing progress towards achievement of objectives laid down in these planning statements. However, most importantly these reforms are couched broadly in terms of management procedures, processes and practices – and not as narrow financial objectives. The cooperation of the unions in the public service is evident in their participation on partnership committees throughout the public service. The structures to support public sector reform are in place as a result of new legislation and successive National Partnership Agreements. These two factors are likely to ensure that this time the reform process will continue to result in significant change in the Irish public sector.

CHAPTER 5

RESEARCH METHODOLOGY

5.1 Introduction

The focus of this study is to examine the use of accounting information in the management of Irish hospitals. The acute hospital sector is a significant consumer of public resources, absorbing almost half of the DoH&C budget (see Table 6.3). This research was motivated by the absence of detailed studies on the use of accounting information in public sector management in Ireland. The need to provide a rich account of the complex relationships between organisational context and the functioning of accounting was identified. A discussion and analysis of NPM in the wider public sector was provided in chapter 2 and 3 and offers a background for an examination of the role of accounting in the implementation of NPM in a specific part of the public sector – the acute hospital sector.

This chapter is organised as follows. The location of the research within the management accounting research literature is outlined concisely in this section. The research objectives are then stated, and a brief description of the case study sites is provided in section 5.2, to provide a context for the discussion of the research approach and research methodology adopted to best address the research objectives chosen for study. In section 5.3 the chapter moves away from the specific to a more general discussion of epistemological approaches so as to provide an outline of the research approaches that could have been employed but were not. The importance of organisational context in management accounting research and the choice of the qualitative research approach are considered in section 5.4. The chapter returns to consideration of the specific in section 5.5 by providing a detailed defence of the choice of the case study research method and the use of the semi-structured interview research technique applied in this study. The adoption of qualitative research approach and choice of both the case study research method and semi-structured interview technique to address the research questions outlined in this study are provided in section 5.6. Section 5.6 brings together the chosen case study research method and evidence from

the NPM literature (considered in detail in chapters 2 and 3) on the importance of context specificity. Details are also provided here on the extent and conduct of the interviews. Data analysis issues such as rigour and validity are considered in section 5.7. This is followed, in section 5.8, by a brief description of the theoretically informed analysis that characterises each case study. The chapter would be incomplete without consideration of the limitations of the methodology employed, and this is done in section 5.9. A summary is provided in section 5.10.

Otley (2003) observed that one reason for the ‘paucity’ of work in the field of management accounting and performance management is that “documentation of internal control practices is not subject to public disclosure” and even if it were, he queries how useful this would be when what is really required is a “description of the ways in which organisational control information is used” (Otley, 2003:324). This research addresses this issue by examining not only the accounting systems but the way in which accounting information is used and viewed by organisational members. This is an attempt to locate the results of the analysis of four case studies within the existing body of NPM literature so as to develop that literature. Van Helden (2005:112) argues that “NPM ...is highly influential” in governmental sector research but is less so in research concerning health care organisations. It is anticipated that this research will assist in developing a greater understanding of the organizational and social functioning of NPM reforms and accounting practice in health care organisations.

5.2 Research Objectives

The objective of this research is to document, analyse and explain the changes in accounting that have coincided with changes in management practices in four Irish hospitals. This overriding objective can be subdivided into component parts:

- 1) How or to what extent is NPM evident in Irish hospitals?
- 2) How are NPM ideas being implemented in Irish hospitals?
- 3) How are accounting techniques being used to support the introduction of NPM ideas in these hospitals?

The sites selected as case studies are four hospitals in two health board areas. In chapter 6 the structure of the Irish health system, health boards and network of hospitals is outlined in detail. Brief details on the hospitals are provided in Table 5.1 to illustrate the differences and similarities between the four case study sites.²²

Table 5.1: Key comparative characteristics of the case study hospitals

	Hospitals			
	Ashford	Maria Theresa	Norhop	Southop
	Health Board 1		Health Board 2	
Acute hospital	✓	✓	✓	✓
Beds	568~	203~	88+	405~
Teaching	✓			
Hospital Status	Regional	Voluntary	Small acute	Regional
Special Characteristics	Is the main general hospital referral unit of the health board and the regional centre for a wide range of specialities	Voluntary hospital which changed from religious ownership to health board ownership in 2001.	Recommended for downgrading to local hospital status under Hanly reform proposals outlined in chapter 6 *	Is the main general hospital referral unit of the health board and the regional centre for a wide range of specialities

Source: * DoH&C (2003e:73)
 ~ The Irish Medical Directory (2003-2004)
 + Area Health Board website ahb.ie

The sites were selected as being typical of the mix of hospitals outside of the Dublin area. Two are large regional hospitals (one is also a teaching hospital) situated in cities serving both the city and geographically dispersed populations in the surrounding

²² The names of the four hospitals and two health boards are fictitious for reasons of confidentiality.

countryside. Maria Theresa and Norhop are acute hospitals situated in small towns and located respectively 60 kilometres and 35 kilometres from the larger hospitals Ashford and Southop. Access to the hospitals was sought from health board chief executive officers, who, having considered a summarized research proposal, agreed to participate in the research. Further detail on selection of staff interviewed is provided in each of the case study chapters.

The primary reason for adopting a fieldwork approach in this case is the need to obtain an in-depth understanding of both the actual and potential uses of accounting and the context in which accounting is used. Accounting is but one element of the organisational control system. It is caught up in wider processes of organisational change (Hopwood, 1990; Hopwood & Miller, 1994). Therefore it is useful to study the development of accounting practices in order to understand the logic of existing practices in the context of changes that have taken place throughout the organisation (Cooper, 1983:283). By including a broad spectrum of organisational hospital members from each of the four hospitals together with relevant staff in the two health boards and the DoH&C, it is intended not only to explore the role of accounting in the organisational context of each of the four hospitals but also the inter organisational connections with the health boards and the DoH&C. This is in line with Roberts and Scapens (1985:444) who argue that:

the only way to understand accounting practice is through an understanding of the organisational reality which is the context of accounting, and which is the reality that the accounting systems are designed to account for.

Consideration is given in section 5.3 to the various approaches that could be used to study accounting. This is followed by a discussion of those approaches and a discussion of the importance of organisational context in gaining an understanding of the nature and use of accounting in organisations. The adopted case study research method is examined in detail in section 5.5.

5.3 Epistemological Approach

There are various approaches that could be used to study accounting in organisations and for each of these approaches there is support and criticism. On the one hand “there are

the objectivists who will deny the validity and generalisability of interpretative studies, whilst on the other are the subjectivists who will deny the ‘meaning’ of positivist scientific methods” (Cooper, 1983:283). At opposite ends of a continuum between the objective and subjective approaches are the constructs of rigour and relevance. The subjective approach is clearly relevant to the work of managers in practice as it involves studying the working of accounting in everyday practice. At the other extreme are studies that adopt the objective approach and pursue rigour at the expense of relevance. However studies that adopt the subjective approach can be both relevant and rigorous, with internal validity considered at both the design and analysis stages of the research process. This is discussed further in the analysis section of this chapter (section 5.7).

Otley (2001:247) notes that the possible conflict between rigour and relevance in the field of management accounting research may deter the researcher from using the less accepted “softer methodological research approaches”. However, he argues that it is important to develop management accounting research which “connects with real organizations and their practices” (Otley, 2001:246). He favours intensive, field-based research methods “to investigate the wide variety of control mechanisms deployed by organisations in practice which can then be used to generate theory inductively” (Otley, 2001:256). This is the approach favoured and adopted in this study.

Those who favour the more deductive approaches may do so for practical reasons, for instance, to avoid problems of gaining access which must be negotiated and maintained during intensive field research such as case study research, and also to ease the burden of analysis in the latter stages of the project as the larger part of deductive research work is front ended (Otley, 2001). In interpretative accounting research the interaction of accounting practices with other social practices in the organisation is examined to better understand not only the nature but the role and use of accounting.

The theoretical orientation of this research may be described as a contextual interpretivist inductive approach. Before discussing this research methodology in detail

a brief historical overview of the research approaches in accounting is provided to locate the current study in its methodological context.

5.4 Research Approaches and the Importance of Organisational Context

There are many approaches that may be used to study accounting in organisations. Until the 1980's the approach to accounting research was primarily positivistic in nature (Humphrey, 2001). During the 1980's the emphasis was very much on introducing social theories into the accounting domain (Covaleski & Aiken, 1986; Humphrey & Scapens, 1996; Humphrey, 2001). Humphrey (2001) suggests that Tony Tinker's book *Paper Prophets* changed this somewhat. He acknowledges that the book gave him "confidence to think differently about" accounting and auditing research (Humphrey, 2001:92) and (Tinker, 1985).

A move away from the positivistic approach had been advanced almost twenty years earlier by Tomkins and Groves (1983) who contended that accounting researchers had been dominated by the research methodology of the natural sciences for far too long and that it was time to consider using naturalistic or interpretative humanistic approaches to give greater insight into everyday effects of accounting. Hopper, Otley and Scapens (2001:283) acknowledge that there is a growing belief amongst British researchers that "advances in social theorising about accounting has outstripped its testing through careful empirical study". This study is intended to assist in filling this gap in the accounting research field.

Since Tomkins et al., (1983) the case for qualitative research has been advanced by many in the management and accounting literature (Morgan & Smircich, 1980; Hopwood, 1983; Tomkins & Groves, 1983; Roberts & Scapens, 1985; Lapsley, 1988; Hopwood et al., 1990; Humphrey & Scapens, 1996; Lapsley, 1997; Jonsson, 1998). Amongst the exponents of qualitative research is Hopwood, who observed that:

What is needed are more substantive investigations orientated towards providing bases for understanding or explaining the working of accounting in action.

Hopwood (1983:302-303)

Support for this view is found in many places including the work of Birnberg, Turopolec and Young (1983) who argue that prior accounting research has suffered from too narrow a definition of accounting and as a result has ignored many of the realities of organisational life.

Accounting is but one part of a carefully designed system of organisational control (Flamholtz, 1983:168) and is now seen as centrally involved in modern forms of organising (Hopwood, 1983; Hopwood & Miller, 1994). A case study based approach is appropriate for the study of accounting control systems, as the role of accounting and other controls cannot be fully understood in isolation. Hopper and Powell (1985:450) argue that:

accounting should no longer be studied in a mode which is divorced from its social context and which ignores the influence of 'wider social and political collectivities'.

Kaplan (1986) suggests that the current lack of theories in management accounting can be attributed to a failure to observe how management accounting work functions in organizations. In the accounting literature over the years Hopwood has made repeated calls for studies of accounting in the context in which it operates, placing emphasis on the significance of the wider economic and social setting of accounting (Hopwood, 1983; Hopwood, 1987; Hopwood, 1990; Hopwood, 1999). He also has advanced the idea that as accounting is not a static phenomenon and as "we have only a limited understanding of the forces that put accounting in motion and the processes accompanying accounting elaboration and diffusion", we need to study accounting in its organisational context (Hopwood, 1987:207; Nyland & Pettersen, 2004). He observes that many examinations into accounting have tended to see accounting as disconnected from the context in which it operates. Hopwood (1990) argues that one of the ways of making organisations more market oriented is through organisational and accounting changes. Miller (1994) and Ahrens & Dent (1998) support this view noting that accounting simply cannot be studied as an organizational practice in isolation from the wider social and institutional context in which it operates.

This study accepts these views of accounting and the importance of examining the wider organisational setting in which accounting is located. Historical antecedents that have shaped the development of the practice of accounting in organisations must be studied to fully understand the current role and use of accounting in organisations. Other reasons to study accounting in practice include the need to bring theory and empirical research together, each informing the other in order that they can both be improved (Laughlin, Hopper, & Miller, 1989), and the need to confront theory or to challenge propositions found in the literature (Spicer, 1992).

Data gathered from extensive field research such as case studies can be used to develop more “insightful theories” as connections are elucidated and explanatory frameworks developed to better understand how accounting works in practice (Otley, 2001:257). Hopper et al. (2001) continue to advance this view that it is important for management accounting theory to be based on an understanding of “how and why managers behave” in a certain way in practice. Baxter and Chua (2003:99) also observe that the interpretivist perspective has yielded interesting studies of management accounting practice, from which we have learnt that management accounting technologies are developed and implemented quite differently from one organisation to another, “conveying values, meanings and nuances”. An examination of accounting across the four different hospitals under two different health board managements will show the similarities and differences in accounting in different contexts.

For all of these reasons it was considered appropriate to adopt a qualitative research approach to address the research objectives outlined above. This concurs with arguments advanced in the literature that the research method chosen in any study should fit the research question (Abernethy, Chua, Lockett, & Selto, 1999). Qualitative research is:

a situated activity that locates the observer in the world. Qualitative researchers study things in their natural settings, attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring to them. ... Qualitative research involves the study, use and collection of a variety of empirical materials... that describe routine and problematic moments and meanings in individuals' lives.

Denzin & Lincoln (2000:3)

Qualitative research provides more than a description of practice. It requires the researcher to attempt to explicitly link the observations to a pre-existing body of knowledge (Ferreira & Merchant, 1992). Within the inductive qualitative contextual approach the case study method was considered the most suitable research method to examine accounting in the organisational context of acute hospitals in Ireland. An outline of the nature of qualitative research and the position of case study research within it follows.

5.5 Case Studies

Case studies as a research method provide an opportunity to study management accounting systems in their organizational context. Lapsley (1988) points to the need for further research on internal accounting and management information systems "in order to develop more informed views of what actually happens in organisations, instead of what outsiders assume to be the norm within organisations" (Lapsley, 1988:28). He recommends the use of the case study approach to enrich data collection. There is support for this view in the later literature (Otley, 1990; Scapens, 1990; Otley & Berry, 1994) where it is argued that there is a *prima facie* case for the use of a case-based research method in developing a fuller understanding of the relative role of accounting and other controls in the management of organisational performance.

Though difficult, a distinction can be drawn on two levels between field research and case study research, although the terms have been used interchangeably in the management accounting literature since the early 1990's (Spicer, 1992). Spicer argues that case study research involves time intensive, detailed investigations of a case site whereas field research is not so time intensive, involving, for instance, a series of short site visits (Spicer, 1992:10). The second difference arises in the approach to the analysis of the data. Unlike in field research, in case study research there is an attempt to relate the analysis of the case study data to the context of the case (Spicer, 1992).

The most obvious hurdle to overcome in field and case study research is “securing adequate corporate co-operation” as by their nature they cannot be effectively conducted without this (Ferreira & Merchant, 1992:19). Details on how this was obtained for the present study are outlined in section 5.2. Lillis (1999) notes that disclosure of method and design are critical in obtaining the trust of readers of field studies. She also observed that “qualitative research ...in accounting lacks an accepted language in which to communicate study design parameters and the critical links between design and credible research outcomes” (Lillis, 1999:80). Hence a detailed outline of the research approach, methodology and method are provided to enhance the validity of the study.

Yin recommends the use of the case study when asking ‘*how*’ and ‘*why*’ questions, when the researcher does not have control over behavioural events, and when the focus of the study is on contemporary events (Yin, 1994:9). He argues that the case study’s unique strength is its ability to deal with a wide variety of evidence – documents, interview, and observations (Yin, 1994). Among the well established techniques of case study research are the use of semi-structured interviews (see below) and the scrutiny of documents (Lapsley & Llewellyn, 1995).

Different typologies of case studies have been suggested. Stake (1994) distinguishes between three types (see Table 5.2) while Scapens (1990) and Ryan, Scapens, and Theobold (2000) identify five types (see Table 5.3).

Table 5.2: Case Study Typology

Type of case study	Reason for undertaking such a case study
Intrinsic	To better understand this case. The case is of primary interest.
Instrumental	To provide insight into an issue or refinement of a theory. The case is of secondary interest.
Collective	The study of a number of cases jointly in order to enquire into a phenomenon. This is really an instrumental case study extended to several cases. They are chosen because it is believed that understanding them will lead to better understanding and perhaps improved theorising.

Source: Stake (1994:237)

Table 5.3: Alternative Case Study Typology

Type of case study	Reason for undertaking such a case study
Descriptive	To describe accounting systems, techniques and procedures currently used in practice.
Illustrative	To provide an illustration of what has been achieved in practice.
Experimental	To see, for example, the difficulties encountered when implementing a new accounting procedure or technique.
Exploratory	To explore reasons for particular accounting practices.
Explanatory	Theory is used to understand and explain specific accounting practices in the particular context.

Source: Scapens (1990:265), Ryan et. al. (2000)

These typologies may offer guidance to the researcher. In some cases whilst the original purpose of the case might be exploratory or explanatory, the analysis of the case may start with a description of the case in an attempt to identify causal links to be analysed (Yin, 1994). The four cases examined here may be described as collective case studies using the Stake (1994) typology and as exploratory and explanatory cases using the Scapens (1990) and Ryan et al. (2000) typology. The primary reason for studying these cases is to better understand the role and use of accounting in implementing NPM ideas.

Unlike survey research, qualitative studies tend to have a distinctive lifecycle, one that spreads data collection and analysis throughout a study (Huberman & Miles, 1994). Changes can be made to the loosely framed interview themes to reflect a growing understanding of the case study setting. Such developments in the data gathering method, reflecting a better understanding of the research setting, increases “the internal validity of the study” (Huberman & Miles, 1994:431). This approach was used to data gathering in all four case studies. Changes were made to the initial themes drawn from a review of the NPM literature as the observations increased and an understanding of the issues specific to the case developed.

There is no such thing as a truly ‘correct’ case study (Humphrey & Scapens, 1996:97), only a case study that seeks to develop a holistic appreciation of the issue under

consideration (Llewellyn, 1992:29). In developing such an understanding the most important things to emphasise with case study research are the general spirit of the investigation and the crucial importance of ideas (Humphrey, 2001:97). Humphrey (2001) observes that the conventional advice to writing up case studies, often heard at conferences, is to be less descriptive, more analytical and clearer on the theoretical perspective and contribution of the case (Humphrey, 2001:98). However the result of such an approach is often a case with a large section devoted to a detailed outline of the theoretical perspective, followed by “its subsequent ...illustration (which) can look artificial” (Humphrey, 2001:98).

Humphrey (2001) argues for cases to be accepted for their individual richness. Rich does not equate with exhaustive, but has more to do with “making understandable the actions and motivations of people who routinely mobilise accounting in their daily lives” (Ahrens & Dent, 1998:4). The construction of the four case studies examined here has endeavoured to be as faithful as possible, drawing on interview transcripts and documents retrieved from the hospitals, health boards and the DoH&C. This research study has endeavoured to mine all observations, interview transcripts and documents to present four case studies rich in insights into the use of accounting to implement NPM ideas in each case study site. Qualitative findings grow out of three kinds of data collection: interviews, direct observation and written documents (Patton, 2002). The most significant source of data in this study derived from semi-structured interviews. Consideration is therefore given below to various interview typologies.

5.5.1 Types of interviews

Interviews may be highly structured, using standardised questions for each respondent, or they may be informal and unstructured conversations. However “asking questions and getting answers is a much harder task than it may seem at first” (Fontana & Frey, 1994:361). Among the advantages of interviews are: the opportunity to address more complex questions, to probe deeper into participants responses, and to identify errors

that go undetected when using other research data gathering techniques such as questionnaires (Pedhazur & Pedhazur Schmelkin, 1991).

Various typologies are used to describe the variety of interviews that may be used to gather research data. Three alternative typologies are provided in Table 5.4. Patton (2002) identifies three different types of interview which may be used by the researcher for different purposes: the unstructured interview, the interview guide – corresponding to the semi-structured interview (Saunders, Lewis, & Thornhill, 2003:246), and the open ended unstructured interview.

Table 5.4: Interview typologies

	Structured Interview	Semi-structured Interview	Unstructured Interview
Patton (2002)	Standardized open-ended interview	General interview guide	Informal conversational interview
Healey and Rawlinson (1994)	Standardized interviews	---	Non –standardized interviews
Fontana & Frey (1994)	Structured interviews	Semi-structured interview	Unstructured

Source: Fontana & Frey (1994), Healey & Rawlinson (1994), Patton (2002).

The informal conversational open ended interview offers flexibility, spontaneity and responsiveness to the researcher working with individual interviewees. Questions can be personalised to deepen communication. This approach requires greater researcher skills than a more structured approach, as the interviewer must be able to interact with people in a variety of settings and simultaneously develop rapid insights and formulate questions quickly without imposing interpretations on the situation by the structure of the questions (Patton, 2002:343). The semi-structured interview guide approach lists either the questions or, more commonly, the issues/themes that are to be explored in the course of an interview. Using this approach the interviewer remains free to expand a conversation within a particular subject area, to word questions spontaneously while

keeping a focus on that area. This general interview guide provides a framework for the interview whilst allowing the researcher flexibility to respond to and expand on responses of interest. The third interview approach requires careful and complete wording of each question before the interview. The weakness of this approach is that it does not allow the researcher to pursue issues that were not anticipated when the questions were written (Patton, 2002). On the other hand such a rigid approach guards against being too open minded which can lead to a lack of focus (Ferreira & Merchant, 1992).

5.6 Research Methods in this Research

Eisenhardt (1989) advises that, in order to build theory from case study research, an initial definition of the research question is necessary. This step has been taken in this study by outlining the research objective and research questions in section 5.2. Important variables were identified from the NPM literature in chapter 2 and 3. The next step involves data gathering.

This study used a triangulation approach to data gathering. In the 1970's Denzin identified four basic types of triangulation: data triangulation, investigator triangulation, theory triangulation and methodological triangulation (Denzin, 1978). Triangulation involves "the combination of multiple methodological practices, empirical materials, perspectives. ... In a single case study it is best understood as a strategy that adds rigor, breadth, complexity, richness, and depth to any inquiry" (Flick, 2002:231). Given that objective reality can never be captured, triangulation is an attempt to secure an in-depth understanding of the phenomenon the researcher is trying to understand (Denzin & Lincoln, 2000:5). This study is interpretational in that it seeks to examine and interpret the accounting control system and relate it to its environment and to the NPM literature. Three kinds of qualitative data were used in this study in an attempt to add rigour, depth and richness to this work: semi-structured interviews, some limited observation and both published and unpublished DoH&C, health board and hospital documents. In addition to this qualitative data, the study draws on archival research sources – historic

government reports and reviews, public records of parliamentary debates, and other documents necessary to provide a comprehensive contextual understanding of the background to the implementation of NPM in these four Irish hospitals.

The case study method provides an opportunity to examine context specific factors that impact on organizational change situations. The success or failure of public management reform is heavily context specific (Pollitt, 2003). Pollitt (2003:122) argues that “a technique or organisational structure which succeeds in one place may fail in another”. Any empirical research method needs to capture this complexity and context specificity. For this reason the case study method was adopted.

Four comparative case studies were used to address the research objectives outlined above. The comparative case study approach examines multiple situations within an overall framework. After cases are built individually they are analyzed comparatively with the objective of seeking out common experiences, patterns, variables and relationships (Agranoff & Radin, 1991; Yin, 1994). Commonalities and divergences between the cases are discussed in chapter 11.

An examination of the literature on NPM suggested a recurrence of a number of themes. These were used to develop a skeletal conceptual framework, from which variables were identified and subsequently drawn on as prompts during the semi-structured interviews. However, interview questions were not limited to these themes. Some questions were based on probes that emerged from discussions with the respondents during interviews. The constructs under investigation such as accountability and performance management did not lend themselves to measurement by a survey method as they are capable of taking on what Abernethy et al. (1999:7) describe as “multiple layers/shades of meaning”. For example, on several occasions during the conduct of interviews respondents asked “what exactly do you mean by accountability?”.

All semi-structured interviews lasted between one and two hours. Tables A1 to A7 in Appendix A contain the details of all fifty-seven interviews. All interviews (but three)

were transcribed and analysed. In carrying out the interviews, each interview commenced with general questions about the interviewee, the nature of his/her job, the difficulties in doing his/her job. These were the 'breaking the ice' questions of the type recommended by Fontana & Frey (1994:371) and were used before moving on to more specific questions. Changes were made to the loosely framed interview themes to reflect a developing understanding of the case study. This was done to reflect a better understanding of the research setting and to increase the internal validity of the study as advised by Huberman & Miles (1994). For a further discussion of validity issues, see section 5.7. Written evidence including reports and sample accounting documentation was collected and examined and will be described and discussed in the presentation and analysis of each case. Statistical information on activity was requested and received from the DoH&C. The study used a variety of published and unpublished internal hospital reports. Data analysis followed data collection in each case.

5.7 Data Analysis

Qualitative analysis converts data into findings and is demanding in large part because the methods of analysis are not well formulated (Miles, 1979). Ferreira and Merchant (1992) observed that there is little guidance available in academic journals on the research and analytical methods actually used by researchers. The analysis of qualitative data involves processes of reduction, classification and interpretation (Lillis, 1999). The challenge of qualitative analysis lies in making sense of large volumes of data (Patton, 2002). Whilst there are not rules for qualitative data analysis there are guidelines:

Finding patterns is one result of analysis. Finding vagaries, uncertainties and ambiguities is another.
Patton (2002:437)

Yin (1994) recommends two approaches to case analysis: using the theoretical propositions that informed the design of the case study or alternatively developing a descriptive framework for organising the case study (Yin, 1994:104). Otley (2003) recommends the "careful use of inductive generalisation to explain observed practice rather than the imposition of inappropriate theories." This approach is in contrast to the

approach to critical case studies during the 1980's when the emphasis was on "introducing social theories into the accounting domain" (Humphrey, 2001:92). Theoretical developments in accounting for several years depended on the introduction of a new social theory over case by case comparisons (Humphrey & Scapens, 1996:92).

Consideration of data analysis, in this study, began at an early stage, as soon as the research questions were formulated and a theoretical framework developed. This ensured an initial and continuing focus and bounded the interview themes whilst allowing for flexibility in conducting the semi-structured interviews at each case study site. Cognisance was taken of the fact that the case method is not used to make statistical generalisations to a larger population. It is used instead for explanatory purposes, as it is in this instance, and depends on "matching patterns of observations made in the case to those suggested by theoretical propositions found in the literature" as advised by Spicer (1992:12). Thus the analysis of the case study data was an iterative process involving frequent rereading of the NPM literature and a continuous examination of the case site data.

Inductive analysis including content analysis and theme analysis was performed on the interview transcription data in an attempt to identify themes and emerging patterns. Content analysis involves analysing text such as interview transcripts and documents (Patton, 2002). This contrasts with deductive analysis where the data are analyzed according to an existing framework (Patton, 2002:453). An analytical protocol was developed to enhance the complete and impartial analysis around the themes which had emerged from a study of the NPM literature. In each case study site as a new theme emerged it was included in the analytical protocol. The use of such an approach "establishes a disciplined approach to both data extraction and analysis that promotes completeness and impartiality" (Lillis, 1999). Yet this approach adopted was not overly restrictive as it facilitated a search for new patterns. Observations were synthesised into themes, around constructs that emerged from the NPM literature or else new themes.

Evaluation of empirical research requires that it satisfy validity concerns of the reader. With case studies it is appropriate to establish whether there is support for causal relations in the case studies and to provide sufficient evidence that the data 'make sense' (Abernethy et al., 1999:20). Case study research does not seek external validity in terms of statistical generalisability but rather in terms of "theoretical generalisability" (Abernethy et al., 1999:22). Analytical iterations of each case were carried out in an attempt to ensure that the analysis was complete, impartial and made sense. Repeated patterns were linked with the NPM and other literatures (discussed in chapters 2 and 3) to develop explanations for the observations and to expand those literatures.

One of the greatest difficulties with the analysis of qualitative data is knowing at what point the analysis is both complete and impartial (Lillis, 1999). Demski and Sappington (1999:21) argue that empirical analysis, of either a quantitative or qualitative nature, is at best an imperfect summary of the central forces at play and could be viewed as a form of summarization with errors. Comment on the limitations of the method applied here is offered (section 5.9). Although there is a separate chapter outlining the conceptual perspective informing this work, a brief synthesis of the conceptual context and the research approach adopted in this research is provided before completing this chapter.

5.8 Theoretical Inferences

Theory is a means of interpreting or making sense of a complex world. Accounting theory consists of theories of the organisational and social functioning of accounting (Humphrey & Scapens, 1996). Humphrey & Scapens (1996:97) argue that accepted theories may be regarded as the observations of the "Establishment". They urge researchers to be prepared to challenge such theories in interpreting their own observations, arguing that theoretical development is in essence "a rhetorical process in which forms of persuasive argument are used to convince others of the merits of a particular view" (Humphrey & Scapens, 1996:99).

The theoretical perspective for this work was informed by the NPM literature discussed in the previous chapter. In order to gain some clarity and precision in developing the research questions, a review of the literature on NPM was undertaken. A review of the literature is often a productive strategy that helps identify issues that require further investigation and can aid in developing more insightful questions (Yin, 1994). A theoretical framework built around the NPM literature offered an identifiable structure to commence the research process. An understanding and application of existing theory in interpreting the data provided a device for adding greater coherence to the observations. Covalleski and Dirsmith (1990:559) argue that the interpretation of case study data can benefit from using a “multi-theoretical perspective to better understand different facets of accounting”. In each of the four cases presented in chapters 7 to 10, an attempt is made to examine the data initially through the NPM lens. When this is not sufficient to provide an explanation for the observations, other literatures (trust, professions, and religious) are drawn upon to better explain the data. This approach also concurs with the suggestions of Humphrey & Scapens that:

The researcher may need to refocus, regrind or reshape the chosen lens and even combine it with other lenses in order to secure a coherent theoretical framework focused explicitly on the issues and questions raised by the case. Relying solely on the content of a pre-selected theory necessarily forces the researcher to work out from the theory, leaving it unchallenged and resulting in a failure to develop a theoretical framework focused explicitly on the issues and questions raised by the case.

Humphrey & Scapens (1996:91)

In examining and attempting to understand the case studies cognisance was taken of organizational dynamics and tensions. As each case was analysed, case study papers were presented at national and international research seminars, workshops and conferences in order to generate feedback and to improve the case analysis. This is in line with advice offered by Abernethy et al. (1999) that the examination of research by peers is part of the advancement of scientific knowledge. A list of the papers presented, together with identification of the stages in the research process, follows in Appendix C.

Regardless of the research approach adopted and of the rigour applied in both the design and analysis, there will be strengths and weaknesses associated with the methodology, as

the object under study is a contemporary real world phenomenon subject to external influences. A brief outline of the limitations is offered below.

5.9 Limitations

There were a number of limitations to the research approach adopted, though few of these could be avoided if the case studies were repeated. On occasion the need to follow up loose threads was not evident until too late, as there were big gaps of time between data collection and data analysis, given the scale of the research project and the teaching commitments of the researcher. One design limitation is that the study is also heavily dependent on verbal reports of respondents. However, the need for and use of respondents or key informants is acknowledged in the qualitative research literature (Rubin & Rubin, 1995). Using a data triangulation approach, attempts were made to confirm verbal reports of respondents in subsequent interviews with other staff in the hospitals, health boards and DoH&C.

The written internal documentation varies between sites. This is in part due to the nature of the research questions and was to be expected as written documentation was not the primary means by which these questions would/could be answered. However, the triangulation approach adopted to data gathering attempted to address this problem in two ways: 1) by collecting documents the hospitals sent to the health boards, and 2) by requesting from health boards documents sent to them by the hospitals. The decision to extend the triangulation approach and interview two senior members of the acute hospital division at the DoH&C also increased the validity of the data, as prior understandings developed after interviews with hospitals and health boards could be discussed, confirmed and developed.

A frequent criticism of small sample work is that it is scientifically unsound. However, in response to this criticism, even the single case study can lead the researcher to see new theoretical relationships (Dyer & Wilkins, 1991). Dyer & Wilkins (1991:618) also warn, however, that “studying a single case in detail doesn’t guarantee that rich

theoretical insights will be the harvest". Yet they encourage this approach in the hope that good stories will emerge that have "theoretical import" (Dyer & Wilkins, 1991:618). In this study, multiple case studies have been developed to address the research questions outlined at the beginning of this chapter.

5.10 Summary

This chapter has outlined the methodological context for the research approach, research methods and research techniques adopted in this study, and has located the research study in the management accounting research literature. The study is in part a response to Otley's (2003) claim of the paucity of work in the field of management accounting describing the ways in which organisational control information is used in practice. There is a dearth of research on public sector management accounting practices in Ireland. Yet there are increasing demands for improved performance and greater accountability, as illustrated in chapters 2, 3 and 4. This study is an attempt to address this gap in the literature, by examining the role of accounting in implementing the NPM ideas in the Irish public sector.

The acute hospitals sector was chosen for study as it is a large consumer of public resources (see Table 6.3). The importance of the organisational context of this study was discussed from a management accounting viewpoint and from the perspective of the NPM changes sought globally by governments. The four acute hospital case studies were introduced and the three research objectives were outlined in section 5.2. These will be examined in detail in each of the case study chapters (chapters 7-10).

The research approach considered most appropriate to address these objectives was outlined and explained – a contextual interpretive approach. Economic, religious and political influences on the hospitals and health boards are outlined in the next chapter. This information, together with the conceptual perspectives discussed in chapters 2 and 3, will be used to develop explanations for the accounting and management practices observed in each of the four case sites.

CHAPTER 6
CONTEXTUAL BACKGROUND ON THE CASE STUDY SITES

6.1 Introduction

In this chapter the evolution of the Irish health system since the foundation of the Irish State in 1922 will be outlined with a particular emphasis on the evolution of current hospital structures. Background details outlining the organisational structures, methods of financing and management of the health service and previous attempts at hospital reform provide the contextual background for the four hospital case studies that follow. The current position of Irish hospitals is the result of a number of factors the most significant of which are listed in Table 6.1 below.

Table 6.1: Factors that have influenced the current organisation, management and financing of Irish hospitals

Section	Issue discussed
2	Historical development of hospitals 1922-2004
3	Management and Financing
4	The Role of the Church
5	Economic Conditions and Social Partnership
6	Reviews and Proposed Reforms
7	Health Strategies, Health Policy, Consultative Documents and Legislation
8	The Current Position
9	The Health Service Reform Programme

Each of these influencing factors will be outlined in turn, in sections two to nine in this chapter, to allow the reader to better appreciate the current position of the hospitals in the four case studies that follow in chapters 7 to 10. Whilst an appreciation of historical antecedents is important in developing an understating of the current organisational

context of the four acute hospitals in this study, so too is a knowledge of the current organisational environment. Although this is provided in sections 6.8 and 6.9 a brief overview of recent developments is offered here. The current context is one of significant change after thirty years of only minor amendments. The regional health boards established under the Health Act 1970 have been abolished with effect from January 1st 2005. Responsibility for management of the entire health service now rests with the Health Service Executive (HSE). Within the HSE structure, a National Hospitals Office (NHO) is responsible for resource allocation, service delivery and performance management of all 53 acute hospitals in Ireland, through 10 initial hospital networks. The 10 hospital networks correspond to the 10 regional health board networks that were abolished. A key focus of the NHO is integrating hospital services with primary care. The advent of the HSE will enable the DoH&C to concentrate on health policy development and advice to the Minister.

6.1.1 Overview of the Irish Health System

Ireland has a two tier health system (O'Loughlin & Kelly, 2004). Approximately 31% of the population are covered by the General Medical Scheme (GMS) and are eligible for free medical care, 45% have private health insurance and a further 6% have cover in the form of a hospital cash plan which provides cover for the insured for hospital accommodation costs as well as providing some compensation for loss of earnings during illness (Watson & Williams, 2001:14). There is some overlap in the above groups which leaves approximately 26% of the population not covered. This group are eligible for access to acute public hospitals subject to some charges but must pay for general practitioner services and for drugs up to a certain limit each month.

The Irish health care system is largely tax-funded. It is a mix of both public and private institutions. There were 11,832 acute hospital beds (excluding day beds) in 2002 (Department of Health & Children, 2002:18). Approximately 20% of these are designated for use by private patients (Watson & Williams, 2001:1). In addition there are an additional 2,500 private and semi-private beds in private hospitals which are used

for elective surgical treatment, maternity care and mental health treatment (Watson & Williams, 2001:1). The number of acute in-patient beds in Ireland (3.4 per 1000 population) is amongst the lowest in OECD countries (14th of 22 countries) and is also among the lowest in EU countries (9th of 13) (Department of Health & Children, 2002). Acute care beds are found in two types of public hospitals.

6.2 Historical Development of Irish Hospitals 1922 – 2004

Within the public hospital sector there are two groups of hospitals: health board hospitals and public voluntary hospitals.

6.2.1 Health Board Hospitals

The health board hospitals were administered by the health boards, and were financed from their budgets, until the dissolution of the health boards from 31st December 2004 and the transfer of their responsibilities to the Health Service Executive (HSE). This group includes regional hospitals, general/county hospitals, district hospitals, and four orthopaedic hospitals. Regional hospitals are hospitals with specialised units not found in most county hospitals. The Ashford (chapter 7) and Southop (chapter 10) case study hospitals are regional hospitals. General/County hospitals provide diagnostic, therapeutic and emergency general medical and surgical care and in some cases maternity services. Norhop (chapter 8) is a county hospital. District hospitals are smaller hospitals, which provide a limited range of medical and minor surgical services in addition to respite care, palliative care, and both short term and long term convalescent care. The fourth case study hospital Maria Theresa was a voluntary hospital which changed to health board ownership in 2001. The history of the public voluntary hospitals is described in detail below as it provides contextual background information on both the organisation and financing of the overall Irish hospital system.

6.2.2 Voluntary Hospitals

The first voluntary hospitals were established by philanthropic individuals or groups of doctors in the eighteenth century in response to a concern for the condition of the sick

poor (Barrington, 1987). The movement began in Dublin with the establishment of the first hospital, Jervis Street Hospital, in 1718. In addition to medical facilities for the poor the hospitals were associated with medical schools, "providing clinical material to train young doctors and develop expertise which might be put to more profitable use among the wealthy later on" (Barrington, 1987:15). Doctors who staffed these hospitals were not remunerated for their services yet appointments were considered attractive as they opened up the possibility to practice private medicine in these hospitals. Apart from the poor under their care in these hospitals, doctors treated the wealthiest sections of Irish society. Doctors were paid for medical tuition and many were rewarded by referral of private patients by former students (Barrington, 1987). Because of the penal restrictions of the period on religious communities, these hospitals were initially entirely lay in character (Consultative Council on General Hospital Services, 1968). Following Catholic emancipation in 1829 a number of Catholic voluntary hospitals were set up which continue to exist today; examples include St. Vincents in Dublin, set up in 1835, and the purchase of a site by the Congregation of the Sisters of Mercy for the Mater Misericordiae Hospital in Dublin in 1851 (O'Shea, 1998). These hospitals provide for the spiritual as well as the medical needs of their patients.

By the 1930's the demand for hospital care exceeded supply (Brown & Chadwick, 1997). The state hospitals in the 1930's had a poor reputation, emanating as they did from the workhouses of the late eighteenth century. These institutions had been used in the early nineteenth hundreds as "instruments of social control, containing the spread of disease and segregating the sick from the healthy" (Brown & Chadwick, 1997:192). They were perceived in a negative light by both the public and the medical profession. The 1989 Commission on Health Funding described the position thus:

Hospitals had been places of last resort for the poor whose housing or family circumstances were so bad that they did not permit even a minimum standard of care. Those who could afford to pay for medical and nursing care were treated at home (Department of Health, 1989:33).

Faced with financing difficulties after World War One, voluntary hospitals began charging patients with means for accommodation costs. By the late 1920's the voluntary

hospitals were faced with a number of problems: a reduction in the value of their endowment funds as inflation rose, a reduction in income from wealthy individuals, and also rising costs to adopt new medical technologies and practices (Barrington, 1987). This in turn resulted in a reliance by these hospitals on fee paying private patients which in turn resulted in criticisms that these hospitals were treating paying patients in preference to the poor for whom the hospitals were intended (Barrington, 1987). By the end of the 1920's the need and demand for hospital care exceeded the capacity of the existing hospital system and the pressure was greatest on the voluntary hospitals (Brown & Chadwick, 1997).

These hospitals lobbied government to allow them to raise funds to ensure their survival. To assist with the funding difficulties the Public Charitable Hospitals (Temporary Provisions) Act, 1930 legalised the promotion of sweepstakes on horse races for hospital funding purposes. The first Hospitals Sweepstakes draw took place on November 17th 1930.

6.2.3 The Hospitals Trust Fund

This sweepstakes initiative emanated from the voluntary hospitals who were experiencing a funding crisis. Monies from the sweepstakes went into a fund called the Hospitals Trust Fund. All monies in the fund, after expenses and prizes were deducted, were distributed to the governing bodies of the voluntary hospitals in accordance with the Public Charitable Hospitals (Temporary Provisions) Act 1930. By June 1931 £1 million had been raised with about 90 per cent of the money coming from overseas (Dail Eireann Debates, 1931). In order to be eligible to receive monies from the fund, voluntary hospitals participating in the sweepstake had to show that they reserved at least one quarter of their beds for non-fee paying patients. The success of the fund attracted the attention of the Minister for Local Government and Public Health and the success of the Hospital Sweepstakes enabled the Minister for Local Government and Public Health to improve local authority hospital services in most counties (Barrington, 1987:114). The mechanism for doing this was a new allocation basis written into the

Public Charitable Hospitals (Amendment) Act, 1931 whereby one third of the fund could in future be applied by the Minister of Local Government and Public Health in "such manner as he shall think fit in or towards the provision, improvement, or equipment" of non voluntary hospitals (section 6.1).²³ The Public Charitable Hospitals Act, 1933 again altered the allocation mechanism for distributing monies from the Hospitals Trust Fund and gave the Minister full control over the distribution of the fund. A Dail Eireann debate confirmed this.²⁴

Sales of Sweepstakes reached a peak of £18 million in 1961 and then declined. After 1961 the annual income of the Hospitals Trust Fund from Sweepstakes never exceeded £3 million and "the Fund had become little more than an accounting mechanism as the State paid for most of the voluntary hospitals' annual deficits of £5 million" (Barrington, 1987:265). The majority of the income had come from outside the State and this had declined as legal gambling opportunities developed elsewhere (Dail Eireann Debates, 2000). By the end of the 1960's Exchequer grants were the main source of income to the fund. An editorial in the Journal of the Irish Medical Association assessed the position of the voluntary hospitals in 1943:

In Ireland the grip of the State on the voluntary hospitals is a result of the lean years following the last war. The subscriptions of the charitable were falling off and the hospitals were getting deeper and deeper into debt. Someone introduced the Sweepstakes for the purposes of getting rid of the debts. Their success was beyond the wildest hopes of the promoters a fact which carried with it the seed of destruction, for it attracted the attention of the State to the distribution of the accruing monies. The State not only got power by statute to take for itself a considerable share but also to control the distribution of the funds, thereby for the first time getting any power to interfere or busy itself in the affairs of most of the voluntary hospitals.It is not easy to see how the voluntary hospitals could have avoided this danger. Many of them were deep in debt and some seemed to be not far from the necessity of closing their doors (Editorial, 1943:25).

²³ The Public Charitable Hospitals (Amendment) Act 1931, inserted a new section 7(1)(a) into the Public Charitable Hospitals (Temporary Provisions) Act, 1930, changing the title to be used on advertisements and sweepstakes tickets from the name of the governing body of each hospital to a general statement "to the effect that such sweepstake is being held in aid of hospitals in the Irish Free State".

²⁴ Under the Act of 1931 provision was made for the sub-division of the Hospitals Trust Fund into two-thirds for the voluntary hospitals and one-third for the local authority hospitals. Under the 1933 Act that sub-division entirely disappeared and a common fund was created. ...The 1933 Act incorporated the ...principle which allowed the Minister for Local Government and Public Health full discretion in the matter as to the best use to which the monies could be applied (Dail Eireann Debates, 1945).

Today the management authorities for this group of hospitals vary widely (Department of Health & Children, 2003b: section H). Some are still owned and operated by religious orders, others are incorporated by charter or statute and work under lay boards of governors. Many of these hospitals are now administered by boards established by the Minister for Health under the Health (Corporate Bodies) Act, 1961. These hospitals are financed to a large extent by State Funds. There are four categories of public voluntary hospitals – general teaching hospitals, general non-teaching hospitals and a small number of cottage hospitals and special hospitals. The public voluntary special hospitals cater for specialties such as obstetrics and paediatrics, and for specialised illness such as cancer, orthopaedics and ear, nose and throat illnesses. Maria Theresa (chapter 8) was a general non-teaching voluntary hospital prior to moving to health board ownership in 2001.

All the voluntary hospitals received money to assist with their operational costs from the Sweepstakes. Due to the success of the Sweepstakes and the relatively large sums of money it was generating, initially for the voluntary hospitals and increasingly for the benefit of state hospitals, it was decided by the Minister for Local Government and Public Health to enact legislation which would facilitate the setting up of an organisation to manage the Sweepstakes Funds. The Public Charitable Hospitals Act, 1933, facilitated the establishment of an advisory body – the Hospitals Commission – to review how best the Sweepstakes money should be used.

6.2.4 The Hospitals Commission

A Hospitals Commission was charged with the task of surveying hospital facilities in each Area and guiding the Minister in the distribution of monies from the Hospitals Trust Fund. By 1935 the proportion of patients treated free in voluntary hospitals had fallen to 40 per cent (Department of Local Government and Public Health, 1936:92). This was due primarily to the financial necessity of voluntary hospitals to rely on income generated from treating private patients to fund operational costs. The first report of the Commission was critical of the perceived lack of access of non-fee patients to

voluntary hospitals and recommended amalgamations to improve facilities and services (Department of Local Government and Public Health, 1936:17/59).

In 1936 the Commission recommended the development of twelve hospital centres for the treatment of acute medical and surgical cases: five regional centres located in Dublin, Cork, Galway, Limerick and Sligo and seven main hospital centres in counties remote from regional centres. Supporting this structure a network of district hospitals, to cater for acute medical, minor surgical and maternity cases, was envisaged (Department of Local Government and Public Health, 1936:8). However, even before the Commission had commenced carrying out its evaluation of the Irish hospital structure in September 1933, work had already commenced on drawing up plans for spending the funds that had become available from the Sweepstakes. In March 1933 it had been agreed to build twelve hospitals in ten counties (Department of Local Government and Public Health, 1933:132/133). The Commission's recommendations of twelve hospital centres could not then be implemented as "it would have been politically impossible for the government to do an about-turn and renege on its commitments by implementing the Hospitals Commission plan for twelve centres even if it agreed with the Commission's radical blueprint" (Barrington, 1987:123).

Payments from the Hospitals Trust Fund to the voluntary hospitals were made on the basis of accounts submitted and quarterly statements of expenditure. The Hospitals Commission in its first report criticised the running of the voluntary hospitals stating "hospitals should be looked upon as business establishments as far as their management is concerned" (Department of Local Government and Public Health, 1936:68). This was the beginning of State involvement in the financial affairs of the voluntary hospitals.

6.3 Management and Administration of the Health Service

Responsibility for health rested with the Department of Local Government and Public Health until 1947 when the Department of Health was established. It was subsequently renamed the Department of Health and Children in 1997 (hereafter the DoH&C or the

Department). From its inception the newly formed department “had to carve out its role within the social and political fabric of its time” (Mahon, 1997:78). The first Minister for Health was appointed to a new health ministry in January 1947. The second Minister for Health was appointed in February 1948 and undertook a substantial hospital building programme financed by funds primarily (£13.5 million of £15 million) from the Hospitals Sweepstakes via the Hospitals Trust Fund over which he had complete discretion (Dail Eireann Debates, 1951). The Minister did not require the approval of Government or of the Minister for Finance to spend these funds (Barrington, 1987) nor was he bound by the recommendations of the Hospitals Commission as facilitated by the provisions of the Public Charitable Hospitals Act, 1933. This left little to fund the increasing deficits of the voluntary hospitals.

By 1949 relations between the Minister and the consultant establishment of the large voluntary hospitals (which were mainly located in Dublin) had worsened, in large part due to a proposal by the Minister to limit further the amount of Sweepstake funds allocated to voluntary hospitals (Barrington, 1987:204). The Minister announced in 1950 that the amount of Sweepstake funds that would be paid towards the financial deficits incurred by voluntary hospitals in 1950, 1951 and 1952 would be capped at the level of subvention paid in 1948 (Dail Eireann Debates, 1950). He proposed taking this action because of a concern for the growing deficits of the voluntary hospitals which had grown from £116,000 in 1938 to almost £400,000 by 1948 (Dail Eireann Debates, 1950). At the same time as the announcement to cap the funding of the voluntary hospitals’ deficits the Minister announced an incentive measure for the hospitals. In order to encourage the hospitals to treat more of the poor, the rate per patient paid by local authorities for treatment in a voluntary hospital was increased by one third. In a Dail Eireann Debate in 1953 the Minister for Health rejected subsequent criticisms made by the voluntary hospitals:

It is alleged that my Department has been more kind to local authority than to voluntary hospitals, that in fact, we have starved the voluntary hospitals and treated the local authority institutions as prodigal sons. An examination of the figures will not support that view, and it cannot be sustained as a reason for the growing popularity of the county hospitals. The method of appointment to professional vacancies, a method

which ensures that the sole consideration is merit, has in my opinion been responsible for the striking success of those institutions (Dail Eireann Debates, 1953) .

This final comment refers to the medical profession which controlled appointments in many voluntary hospitals (Barrington, 1987:318).

The health services remained in the control of the local authority administration until 1st April 1971 when the Health Act 1970 provided for the setting up of health boards and the dissolution of the Hospitals Commission. The 1970 Health Act reduced the Department's direct involvement in the execution of health policy and eight health boards were given statutory responsibility for the delivery of services in their respective areas. This structure remained unchanged until 2000 when the Eastern Health Board was replaced by the Eastern Regional Health Authority (ERHA).²⁵

6.3.1 Financing of the Health Service

Changes were not made to the financing of the health service, which had been primarily financed from local taxation (84%) in the form of rates, until the passing of the Health Services (Financial Provisions) Act, 1947 (Hensey, 1988:43). This Act ensured that half of the cost of all health services in the future would be met by a state grant. The Health Act, 1953, extended hospital and consultant services to 85% of the population for a nominal charge. Approximately fifteen per cent of the population were not entitled to free health services under this Act. The Voluntary Health Insurance Act, 1957, set up a board to operate voluntary health insurance schemes on a not-for-profit basis for those who were not entitled to free hospital services and for those who were entitled, but who wished to opt for private insurance to avail themselves of private hospital care. The Voluntary Health Insurance Board became the monopoly private health insurance provider in Ireland until the implementation of the European Union Third Non-Life

²⁵ The ERHA is the statutory body with responsibility to plan, arrange and oversee health and personal social services for the 1.5 million people (38% of the population) who live in Dublin, Wicklow and Kildare. The Authority is not directly involved in the delivery of services. Services in these areas are delivered by three new area health boards – the Northern, East Coast and South Western Area Health Boards – and thirty-six voluntary providers.

Insurance Directive via the Health Insurance Act, 1994. The Directive sets out the requirements for member states regarding health insurance whilst allowing member states discretion to adopt the specific requirements in whatever way is considered most appropriate for their legal and national health system. BUPA entered the Irish market for health insurance in 1996 and has gained a relatively small market share (see Table 6.2). In October 2004 a third company Vivas entered the health insurance market.

Table 6.2 Private Health Insurance Customers

	VHI	BUPA
2002	1,500,000	282,000
%	84%	16%

Source: Voluntary Health Insurance Board (2004)

The number of insured persons has risen primarily because of the speed and certainty of access to healthcare which the holding of insurance provides (Deloitte & Touche, 2001b:7).

Currently resources are allocated by the DoH&C using incremental increases to an historical base with adjustments for pay costs, service developments, funding for agreed specific items and casemix²⁶. The problem with this historical cost incremental approach is that it militates against medium and long term development of infrastructure and service development (Deloitte & Touche, 2001b:6) and can lead to an inequitable and potentially inefficient allocation of resources as between competing health boards (Deloitte & Touche, 2001b:6). Today the provision of money to finance public health services is made through the annual estimates and allocation process. Non capital public health expenditure accounted for 26.8% of government spending in 2004 (Irish Government, 2004:9). Of this 48% is consumed by the hospitals programme. Despite the increased allocations there are significant public concerns with the provision of a

²⁶ See footnote 12 for an explanation of casemix.

quality public health service which translated into the election of six independent “health candidates” to the Irish parliament in the most recent national parliamentary election in 2002 (Houston, 2002).

Table 6.3: Exchequer Allocation to Health 1997– 2004

Year	Gross Vote €Million	Increase €Million	% Change	Cumulative % Change
1997	3637	--	--	--
1998	4125	488	13.4%	13%
1999	4831	706	17.1%	33%
2000	5656	825	17.1%	56%
2001	7077	1421	25.1%	95%
2002	8353	1276	18.0%	130%
2003	9302	949	11.4%	156%
2004(est)	10079	777	8.4%	177%

Source: Revised Estimates for Public Services 1997-2004
(Irish Government, 1997 - 2004). Note: unadjusted for inflation.

In addition to these monies relatively small amounts of additional funding for the health services are provided by the National Lottery (see Appendix D). Whilst funding has influenced the development of the health service, the role of the Catholic Church has also had a substantial influence on its development.

6.4 The Role of the Church

The formation of state policy in all areas from the 1930’s onwards was influenced by the Catholic Church’s principle of state subsidiarity (Mahon, 1997). The Church opposed “excessive state control which it legitimated in terms of opposition to state communism”

(Mahon, 1997:79). A further reason for the opposition of an increased role for the State in the lives of the people was the fear of a national health service which would provide services not in accordance with Church teaching. In 1929 in response to the hierarchy's demand for legislative change, the government passed the Censorship of Publications Act (Mahon, 1997). This made it unlawful to print or publish "any indecent medical, surgical or physiological details the publication of which would be calculated to injure public morals" (Hogan & Whyte, 1994:947). This included information on contraception and abortion. In an encyclical of 1930 on Christian marriage Pope Pius XI warned Catholics against divorce, contraception and abortion (Fremantle, 1963). The letter outlined the Church's view on the role of the state the family. The encyclical underlined the duty of religious authorities to intervene to ensure that the moral order was preserved (Barrington, 1987). Barrington noted that few in Ireland would have disagreed with the Church's view in principle "because the teaching coincided with Irish views on the minimalist role of the state in matters affecting the individual and the family" (Barrington, 1987:144). The Criminal Law Amendment Act, 1935, prohibited the importation and sale of contraceptives.

6.4.1 A Plan for the Health Service

Throughout the 1940's the Church continued to encourage the formation of voluntary organizations to help the poor and the sick. The influence of the Church's social teaching was apparent in a report, by Bishop John Dignan, on a proposed national health insurance scheme published in 1945. His plan was an explicit alternative to a state organised health service. His report argued that "social services should be built on the strong foundations of Christianity and not on the shifting sands of 'economics'" (Dignan, 1945:36). Dr. Dignan recommended the removal of health services from the remit of the local authority, the transfer of responsibility for health to a governing body under the National Health Insurance Society, an extension of insurance to finance the new system, and hospitals as the central agency of cure and the axis around which the whole range of medical care would revolve (Dignan, 1945:20). He argued that the Church should be represented on the central and on regional committees which would

supervise the service (Dignan, 1945:33). The report was not well received by the Minister for Health in early 1945. In a Dail debate the Minister stated that:

examination revealed that the paper in general did not take due cognisance of the several very complex fundamental difficulties which the author's proposals involved, that many of these proposals were impracticable, and that accordingly no further action on the basis of the paper would be warranted (Dail Eireann Debates, 1945).

In the early 1940's the Chairman of the Irish Medical Association, also prepared a plan for the future direction of the health service. Having failed to reach agreement with members of his committee he went ahead with publication of his proposal in the Journal of the Irish Medical Association (JIMA) in April 1944. He recommended: the appointment of a Minister for Health; an end to an association between health provision and local government; the appointment of a medical council with wide executive powers; the division of the country into four regions for health purposes to be administered by regional councils; the provision of hospital, consultant and specialist treatment free of charge to a larger segment of the population; and in the area of non hospitals services – group practice, health clinics, and a choice of doctor (Shanley, 1944:41).

The proposal was rejected by the Medical Association and a compromise proposal appeared in the JIMA in December of 1944 recommending a separate Ministry of Health but much more restrictive criteria for availing of free medical general practitioner services. The Irish Medical Association proposals were compared unfavourably with the Dignan proposal (Barrington, 1987). There were some commonalities between the two schemes. Both criticised the bureaucratic nature of the health service. Both agreed that insurance was a better way of financing the health services than local rates or taxation. The influence of the Catholic Church prevailed.

6.4.2 Family Planning Legislative Control

The sale of contraception continued to be illegal until the passing of the Health (Family Planning) Act of 1979 when it became permissible to provide contraceptives, on a prescription basis, primarily for family planning purposes:

A registered medical practitioner may, for the purposes of this Act, give a prescription or authorisation for a contraceptive to a person if he is satisfied that the person is seeking the contraceptive, *bona fide*, for family planning purposes or for adequate medical reasons (section 4.2).

It was not until 1985 that the government amended legislation permitting the sale of condoms without prescription to those aged 18 and over. In 1993 the Health (Family Planning) (Amendment) Act obliged health boards to provide family planning services. The influence of the Church in State affairs and in particular in the development of the health service was persistent. The development of the hospital service was also set against the backdrop of economic conditions.

6.5 Economic Conditions

In the mid 1980s Ireland suffered from a severe economic recession. The national debt was approximately 140% of GNP. Falling growth rates were leading to record levels of unemployment. National Plans in the 1980s focused on improving social services for all whilst reducing unemployment. The National Plan published in October 1982, *The Way Forward*, was not implemented and served only as a manifesto for the November 1982 election. The next government's plan *Building on Reality 1985-1987* had a relatively long gestation and was only published in October 1984. Its results were the familiar mismatch between targets and outcomes (Honohan, 1987). Under the hospital development programme of the sectoral plan for health it was noted that "the efficiency and cost-effectiveness of the hospital system will be improved by using modern management information systems in administration" (Irish Government, 1984:97). Yet there was minimal funding to achieve this objective.

In 1987 the first social partnership agreement was born at "a time of economic crisis that helped to both galvanise a common view of the major sources of Ireland's malaise and build the will to cooperate to remedy them" (International Monetary Fund, 2004:43). The Irish Congress of Trade Unions proposed a way forward based on agreement between the Government and the other Social Partners (the Irish Congress of Trade Unions, the Federation of Irish Employers, the Construction Industry Federation, and

farming organisations). The aim was, through a national consensus, to plot a way out of the country's economic difficulties. In return for wage moderation there were a series of measures to stimulate employment, to broaden the tax base to permit lower taxation of workers' earnings and commitments to improve social protections. The context for the implementation of this plan differed from earlier and later contexts. Although the incoming Fianna Fail government was in a minority position in Dail Eireann, it enjoyed the conditional support for its policies offered by the main opposition (Fine Gael) leader.²⁷ A further difference was that:

that this document was negotiated with the social partners, not presented to them as a *fait accompli*, and provided for an explicit trade-off between wage restraint until 1991 and job creation targets and so helped to ensure relative industrial peace in both private and public sectors (Kane, 1996:122).

This plan The Programme for National Recovery 1987-1990 was implemented successfully. This heralded the beginning of social partnership agreements in Ireland and was the beginning of the turning of the economic tide.

6.5.1 Social Partnership in Ireland

Successive National Partnership Agreements have contributed significantly to the increase in employment rates and growth of the Irish economy which in recent years has been the fastest growing economy in the OECD (International Monetary Fund, 2004:5). Between 1993 and 2003, real income per capital rose by a cumulative 71% when GNP is used as a measure of aggregate income, resulting in Ireland's income levels converging on those of other industrial countries on a per capita basis (International Monetary Fund, 2004:3). To date, six national social partnership plans have been agreed focusing on the maintenance of an innovative and competitive business environment (see Table 6.4). The most recent plan Sustaining Progress 2003-2005 notes that: "the key principle guiding the change agenda overall is aligning the delivery of services to the preferences and requirements of service users and the need for accountability in relation to very substantial investment levels" (Irish Government, 2003: para 23.21).

²⁷ This was known as 'the Tallaght Strategy'.

Table 6.4: National Partnership Agreements

1987 - 1990	Programme for National Recovery (PNC)
1990 - 1993	Programme for Economic and Social Progress (PESP)
1994 - 1996	Programme for Competitiveness and Work (PCW)
1997 - 2000	Partnership 2000
2000 - 2003	Programme for Prosperity and Fairness (PPF)
2003 - 2005	Sustaining Progress

Sustaining Progress 2003-2005 sets out pay increases for each part of the public service (e.g. health, education, local government) which are dependent on verification of satisfactory achievement of levels of co-operation with flexibility and ongoing change, satisfactory implementation of the agenda for modernisation, and the absence of industrial action in respect of any matter covered by the Agreement. This the sixth Agreement notes that it intends addressing the problem created by the restrictive recruitment system known as the Common Recruitment Pool. This system provides for the filling of clerical/administrative posts at grades IV to VII²⁸ by competition confined to employees of health boards, local authorities and other health and local government agencies. Sustaining Progress provides for a cross-sectoral review of recruitment issues including examination of a graduate entry level grade (Irish Government, 2003: para 23.16).

The first of the six agreements A Programme for National Recovery 1987-1990, addressed the need for co-operation from all sectors of the economy to reach agreement on a way to manage Irelands deteriorating economic position. This had led to closure of hospital beds and a reduction in the capacity of the acute hospital sector. The availability and funding of acute hospital beds mirrored the state of the nation's economic position. Table 6.5 shows the reduction in acute hospital beds brought about by ward closures from 1980 to 2000, at a time when the population of the country was increasing. At the same time the number of day cases increased dramatically, average

²⁸ Grade III is the most junior grade for recruitment into the health service.

length of stay reduced and almost the same number of patients were seen in 2000 as in 1980 with a 33% reduction (5,833) reduction in bed capacity. However, the unseen figure is that of public hospital waiting lists which continued to grow during this period.

Table 6.5: Acute Hospital Bed Statistics

Year	Beds	Inpatients	ALOS*	Day Cases	Waiting Lists ²⁹
1980	17,665	543,698	9.7	8,377	---
1990	13,753	522,864	6.9	124,748	---
1995	11,953	529,393	6.6	207,308	26,796~
2000	11,832	548,834	6.6	319,837	31,851~

Source: DoH&C (2002: Table 1.1),
~ DoH&C – Waiting List data published quarterly,
* ALOS – Average Length of Stay

To date the influence of the Church, government funding and national economic conditions on the development of the health service have been outlined. It is against this background that reviews and proposed reforms of the health service took place. Key review documents, health strategies and relevant legislation are outlined in the remainder of this chapter.

6.6 Reviews and Reform of the Health Service

Since the foundation of the State in 1922 several committees and commissions have been established to review the working of the health service and to provide guidance for the Minister for Health. The first such commission was the Hospitals Commission established in 1933 whose functions were outlined in section 2.4. The Minister was not bound by the reports of this Commission. In 1968 and 2003 there were similar reports

²⁹ Comparable data is available only from the beginning of the Waiting Lists Initiative in 1993. Waiting list figures do not include the growing number of patients waiting for day surgery which were only included for the first time in waiting list data published by the Department of Health & Children in September 2002. This is significant in that day case treatments accounted for 68% of elective (i.e. non-emergency) hospital activity in 2000 (Department of Health & Children, 2002) and 38% of all hospital activity in that year. This compares with 2% of all non-outpatient care in 1980.

recommending a rationalisation of health service organisational structures (Consultative Council on General Hospital Services, 1968; Department of Health & Children, 2003a, 2003e). Each of these reports together with other reports will be outlined, in chronological order, to place the current healthcare reforms in their historical context. In order to present a coherent historical review the primary reports, strategies, white papers and legislation are identified in the Table 6.6 below and will be discussed in columnar order. A discussion of the three most recent reports listed in Table 6.7 follows.

Table 6.6: Chronological list of key reviews, reports, strategies and legislation affecting the development of acute hospital services in Ireland

	Reviews of the Health System	Health Strategies	White papers and Legislation
1966			White Paper1966: the Health Services and their Further Development
1968	Fitzgerald Report, 1968		
1986		Health: the Wider Dimension – A Consultative Document, 1986	
1989	Commission on Health Funding, 1989		
1994		Shaping a Healthier Future, 1994-97	
1996			HAA 1996
1998		Working for Health and Well- Being, 1998-2001	
2001	Value for Money Audit of the Irish Health System, 2001	Quality and Fairness – a Health Strategy for You, 2001-2008	

Table 6.7: Recent Healthcare Reform Reports

Year	Reform Reports
2003	The Prospectus Report
2003	The Brennan Report
2003	The Hanly Report

Three review documents have been identified as having an influence on the development of acute hospitals – The Fitzgerald Report 1968, the Commission on Health Funding Report 1989, and the Deloitte and Touche Value for Money Audit of the Health System 2001. Each of these is discussed in turn below before reviewing more recent health strategies, legislation and the three 2003 reports.

6.6.1 The Fitzgerald Report 1968

The Fitzgerald Report published in 1968 made recommendations on the organisation and location of hospital services not unlike the most recent 2003 Hanly Report (Consultative Council on General Hospital Services, 1968; Department of Health & Children, 2003e). The Council recommended four regional hospitals (Cork, Galway and two in Dublin) and nine general hospitals in Dublin and around the country (each having at least 300 beds). This was not dissimilar to the recommendation of the Hospital Commission in 1936, which recommended five regional hospital centres and seven main hospitals (see section 6.2.4). The Fitzgerald rationale for the concentration of specialist services in the larger units was the possibility of a greater number of medical personnel/specialisms and better equipment which would be possible in such hospitals. A smaller number of well resourced and high calibre hospitals were considered preferable to a larger number of inadequately resourced ones. The government of the day while accepting the general principles of the Fitzgerald Report did not accept the specific recommendations on the application of these principles throughout the country. Hensey writing twenty years later noted that “despite the medical case for the proposal to concentrate the services, it was not politically practicable to consider their full implementation” (Hensey, 1988:125). The government adopted a hospital plan in 1975 which proposed that the number of

county hospitals giving full medical and surgical care be reduced from twenty four to fourteen.

However, this plan has been eroded over the years by decisions to retain almost all the county hospitals. There was a lack of political will to support adoption of the recommendation to develop some hospitals as centres of excellence and down grade others to community health clinic status. A similar proposal (The Hanly Report) was considered by Government in 2003 and adopted as government policy (Department of Health & Children, 2003e). However, the political will to implement the changes may or may not be forthcoming.

6.6.2 The Commission on Health Funding (1989)

The terms of reference of the Commission were:

to examine the financing of the health services and to make recommendations on the extent and source of the future funding required to provide an equitable comprehensive and cost effective public health service and on any changes in administration which seem desirable for that purpose. (Department of Health, 1989:1)

The Commission stated that in its opinion:

the solution to the problem facing the Irish health services does not lie primarily in the system of funding but rather in the way the services are planned, organised and delivered. (Department of Health, 1989:15)

Among the major defects identified in organisational structures were: inadequate accountability within the existing structures, absence of evaluation of effectiveness, efficiency and quality of service, insufficient integration of related services, insufficient role in the decision-making process for information and evaluation, and confusion between political and executive functions (Department of Health, 1989:15).

They observed that the then present structure confused the political and executive functions and that the Minister for Health, whose role is primarily a political one, was expected to deal with executive type health issues at national, local and even individual patient or constituent level (Department of Health, 1989:152). They found that the

Department of Health whose primary responsibility is to support the Minister in the formation of policy and the review of health services was taken up with day to day management issues despite the fact that management of the health service is the statutory responsibility of the health boards under the 1970 Health Act. One of the key recommendations of the report was for the transfer of responsibility for the overall management of health services to an executive authority thereby allowing the Department of Health to concentrate on health policy. The report also criticised the lack of accountability, in particular the absence of clear and detailed objectives for those providing the services (Department of Health, 1989:157), noting that the absence of clearly stated objectives makes it difficult for both the monitoring party and monitored party to be accountable. The recommendation of a national manager – the Health Service Executive – is being implemented fifteen years later in 2005 (see earlier discussion in section 6.1).

6.6.3 Value for Money (VFM) Audit of the Irish Health System (2001)

This report argues that “the reality is that, other than anecdotal, the Irish healthcare system cannot on any evidence based approach demonstrate definitively that VFM is being achieved” (Deloitte & Touche, 2001b:7). They also argued that the absence of adequate, comparable information systems militates against ongoing monitoring and assessment of efficiency and effectiveness of how services are provided. The lack of consistency in management information systems and the absence of reliable databases are two further reasons advanced for the failure of the health service to move quickly in developing an effective VFM process. The report also recommended a review of organisational structures and a move to a three year multi annual commitment to funding as a prerequisite to effective policy implementation arguing that the current annual budgeting process is not conducive to planning.

6.6.4 Issues Identified in These Reviews

A number of issues were identified in these reviews that will arise again in sections 7 and 8 of this chapter. The need for rationalisation of the hospitals network was

identified. The absence of accountability mechanisms and information systems to support the discharge of accountability was highlighted. The confusion over the executive and political functions of the Minister was identified as a problem. These are themes that will appear again in the next ten pages in a continuing review of the Irish hospital system.

6.7 Health Strategy, Policy, and Consultative Documents

Health policy and strategy have been further influences on the development of Irish health services. The 1966 White Paper which was a precursor to the 1970 Health Act is outlined below. A further consultative document published in 1986 with an increased focus on health promotion is also discussed as are the three most recent health strategies. Each of these documents are antecedents of the healthcare management changes that emerged in the 1990's.

6.7.1 White Paper 1966: the Health Services and their Further Development

The bulk of the White Paper was aimed at detailing improvements in services. Legislation to implement the paper was not forthcoming until 1969. The White Paper also proposed to reduce the reliance on local rates as a method of funding the expanding health service (Irish Government, 1966:59). In return for reduced local funding of health services, local authorities were expected to surrender their autonomy over the development of local health services (Irish Government, 1966:62). It was envisaged that new regional health boards would be composed of representatives of the medical and related professions, local authority members and others appointed by the Minister for Health (Irish Government, 1966:65).

In this way the voice of local representatives would still be heard. The Health Act, 1970, later gave effect to this proposal by establishing eight regional health boards with significant political representation. For example, in the health board area where Ashford and Maria Theresa Hospitals are located, seventeen of the thirty one members (54.8%) of the Board were elected public representatives.

6.7.2 Health: the Wider Dimension, 1986

In 1986 the Department of Health published a consultative document *Health: the Wider Dimension* on health policy (Department of Health, 1986). This review document was initiated because of two challenges facing the Department of Health – the challenge of achieving the health targets under Health for All, the World Health Organisation initiative, and the challenge of providing increased health services in a time of economic constraint. One of its objectives was to move from a complete focus on curative medicine to a new focus on preventative medicine. It identified the need within the health care system for greater accountability and closer integration between the statutory and non-statutory sectors. The monitoring of quality of care was also identified as a priority. The report invited feedback from all sectors of the health services.

There was little actual change over the next eight years. However, both this report and the Report of the Commission on Health Funding, 1989 were key influences on the development of the first of three health strategies which provided a strategic plan for the overall health service in the 1990's and beyond. The first of these strategies was *Shaping Healthier Future 1994-1997*.

6.7.3 Shaping a Healthier Future 1994-1997

Ireland's health strategy *Shaping a Healthier Future* was produced in 1994 (Department of Health, 1994). The patient was placed at the top of the organisation chart in an attempt to turn the health delivery system, from a focus on the organisation or profession, towards the patient (O'Dwyer, 1997:253). The strategy attempted to develop an overall strategic planning process for the health care system through the integration of key policy objectives and principles into a single framework. It was centred around three key principles, equity, quality of services and accountability. This was "a well considered and rounded strategy, which created a coherent framework within which health policy could be developed" (Deloitte & Touche, 2001b:18). However, it was criticised for a lack of an implementation, evaluation and monitoring framework (Deloitte & Touche, 2001b:18). It was also criticised for failing to include policy

development for acute hospital services and in particular for Accident & Emergency services. The implementation of this strategy coincided with the enactment of the health accountability legislation, the HAA 1996 (see section 6.7.7 below). However, it created an awareness of the legal requirement for accountability for resources and impacted on staff in acute hospitals in that they were now required to prepare a service plan for their individual service areas and to consider the best use of resources on an annual basis. This was the objective. However, the actual process of service planning in each of the four hospitals deviates from its original objective and will be discussed in the four case studies (chapters 7-10).

6.7.4 Working for Health and Well-Being 1998-2001

This was the second health strategy of a new government who took up office in July 1997 (Department of Health & Children, 1998). It recognised that the first strategy had started a process of change for the DoH&C and it undertook to redefine the role of the Department and to devolve to health agencies functions not directly related to its role and to redefine its relationship within those agencies. It recognised inadequate accountability within the organisational structures and the over involvement by the Department in the detailed management of the health services. Objectives identified in the strategy included the strengthening of accountability at all levels within the health service, the encouragement of effectiveness, efficiency, equity, quality and value for money in the health delivery system.

6.7.5 Quality and Fairness – a Health Strategy for You 2001-2008

In 2001 the DoH&C introduced the third health strategy. The repetition of key principles from earlier strategies was in evidence. This strategy was centred on four key principles: equity, people-centeredness, quality and accountability (Department of Health & Children, 2001a). Equity of access, quality and accountability are themes that run through each of the three health strategies. Yet as will be seen in the analysis of the case study data (chapters 7-10) not all of these principles underlie the present acute hospital system.

This third strategy contained four goals: better health for everyone, fair access, responsive and appropriate care delivery, and high performance. The Minister and members of the report group noted that achievement of these goals was only possible within a framework of change across key components and elements of the system which would involve: a strengthening of primary care, reform of the acute hospitals system, funding of the health services, development of human resources, organisational reform and development of health information. Implementation of this strategy is interlinked with the Health Service Reform Programme which is currently underway and is outlined later in the chapter (section 6.9).

6.7.6 Reforms: the Few Implemented and the Many Promised

The most significant reform to have taken place is the codification of NPM ideas in the HAA 1996 which increased the accountability of Chief Executive Officers (CEOs) of health boards. In interviews with hospital and health board staff this was frequently referred to as “the accountability legislation”. This legislation, the current status of the Health Service Reform Programme and other drivers of change are outlined below.

6.7.7 The Health (Amendment) (No.3) Act 1996

The Health (Amendment)(No.3) Act, 1996, referred to throughout this study as the HAA 1996, extended some of the elements of NPM to the health sector. The 1996 Act was designed to strengthen and improve arrangements for financial accountability and expenditure control procedures in health boards. The HAA (1996: section 2) requires health boards to secure the most beneficial, effective and efficient use of resources. It significantly enhanced the role and responsibilities of health boards and their CEOs and provided the legal framework for service planning. The preparation and adoption of a service plan within forty two days of receipt of budget allocation for the forthcoming year is now a legal requirement (section 6). It is the function of the CEO:

to implement the service plan on behalf of the Board so that: net expenditure does not exceed the determination and indebtedness does not exceed the amount specified. If the CEO is of the view that either of these conditions would be breached by decision of the board he must inform the board and the Minister (HAA, 1996: section 9).

Under this Act, accountability of health board CEOs is to be discharged by means of an annual service plan which is to be drawn up, agreed by the health board and implemented by the board in accordance with the assigned allocation of monies from the DoH&C. Any overrun on the budget will in future be carried forward as a first charge on next year's budget.

6.8 The Current Position

Health sector reform has been subject to a similar lack of commitment to substantive reform that prevailed over the public sector generally since the foundation of the State (see Robbins & Lapsley (2005, forthcoming)). In 2003, three reports were published by the Irish Government addressing difficulties and weaknesses in the health sector. The Prospectus Report addressed the issue of structures and functions in the health system (Department of Health & Children, 2003a). The Brennan Report examined financial management and control systems in the health service (Department of Health & Children, 2003d). The report identified a management vacuum at the heart of the health service and it recommended the establishment of a Health Services Executive to manage the health service, thereby allowing the DoH&C to focus more fully on health policy. This echoes the recommendation of the Commission on Health Funding, 1989 (discussed in 6.6.2). The Health Services Executive (HSE) has been formed and took over responsibility for management of the health services from January 1st 2005, at which time the regional health boards were abolished, although health board staff have been asked to retain their positions and continue with their responsibilities until July 1st 2005.

The third report The Hanly Report examined Medical Staffing issues (Department of Health & Children, 2003e). The motivation for the appointment of the Hanly task force was the requirement by Government to implement an average 58 hour working week for non-consultant hospital doctors (junior doctors) by 1st August 2004, and a 48 hour working week by 2009, under EU legislation (European Directive 2000/34/EC). The present government has accepted The Hanly Report which recommends the appointment

of 2,000 extra hospital consultants and major reforms, including withdrawal of A&E, obstetric services and out of hours consultant cover from many smaller hospitals (Department of Health & Children, 2003e).

The present acute hospital system depends heavily on junior doctors. In 2002, seventy percent of all hospitals doctors were junior doctors (Wren, 2004:62). The intention going forward is that clinical care in acute hospitals will be consultant-provided rather than consultant-led as it is at the moment. A consultant-provided service is defined as “a service delivered by teams of consultants, where the consultants have a substantial and direct involvement in the diagnosis, delivery of care and overall management of patients” (Department of Health & Children, 2003e:22). This contrasts with a consultant-led service defined in the Health Strategy (2001) as “a service supervised by consultants who lead and advise teams of doctors in training and other staff in the delivery of care to their patients” (Department of Health & Children, 2001a:203). The present system is consultant-led with many public inpatients and outpatients attended to by junior doctors and only very occasionally having the benefit of a consultant hospital doctor’s opinion.

Equity of access of entry to acute hospitals is also disregarded consistently by a policy in Irish public hospitals that favours the ability to pay (by those with health insurance) over medical need. The present system facilitates and provides incentives to encourage doctors to practice private medicine in public hospitals, as on average twenty per cent of beds in public hospitals are ring fenced for private patients’ use. The Health (Amendment) Act, 1991, provides for the majority of beds in public hospitals (intensive care beds are excluded from the designation) to be designated as public or private beds and provides for the monitoring of the use of all public hospital beds. Private beds are used for both emergency and elective treatment of private patients, with the hospital consultant receiving a fee for treating the patient from the health insurance provider, in addition to a salary from the DoH&C. Conroy (1997:60) uses the analogy of a reward system in a bar to describe the working of the public-private mix in practice: “if a

publican paid her barman by the hour for covering the bar and by the drink for covering the lounge, it would be hard to get served in the bar". This reward system illustrates the difficulty for public patients in trying to access care in public acute hospitals.³⁰ The public are increasingly aware of the potential inequalities and shortcomings in the public hospital system (Forum on Medical Manpower, 2001:17) and it is this concern that is fuelling political interest in reform of the system. The mix of private and public patients in public hospitals creates problems for hospital management attempting to maximise efficiencies. The three most recent reviews of the workings of the hospital system recognise these characteristics and recommend change. The Health Service Reform Programme integrates key recommendations of the Prospectus, Brennan and Hanly reports (Department of Health & Children, 2003a, 2003d, 2003e, 2004a).

One factor that has militated against reform in 2004 has been the industrial disquiet caused by the response of consultant hospital doctors to a change in how they are insured for professional liability, commonly referred to in the media during 2004 as the "medical indemnity crisis". The crisis arose when the Medical Defence Union (MDU) announced that it was to increase its premiums for consultant obstetricians in Ireland to in excess of £300,000 (sterling). In February 2004, the Irish government introduced a new scheme for hospital consultants, called the Clinical Indemnity Scheme (CIS), with the State now acting as the main insurer for consultants. However, no arrangements were made between the government and the MDU in relation to historical liabilities – medical claims for incidents that had taken place in the past and which had yet to be processed through the courts. The Irish Medical Organisation (IMO) representing some consultants were not satisfied with the guarantee from the Minister for Health & Children that no consultant would be left uncovered, and deferred strike action in March 2005 to await clarification of the Minister's guarantee. The Irish Hospital Consultants Association (IHCA), representing the majority of hospital consultants, accepted the written assurances of the Minister in May 2005. Restrictions on "co-operation with the

³⁰ Wren (2004:61) estimates that "public hospital consultants' incomes ranged in 2002 from €149,000 for those with no private practice to an average of €280,000 for those with significant private practice".

DoH&C and its agencies [i.e. health boards]” which commenced in February 2004 have now been lifted by the IHCA. “Normal clinical activity continued uninterrupted by the campaign of action during this time”, (Letter from the Irish Hospital Consultants Association). This issue has restricted progress on the health service reform programme outlined below.

6.9 The Health Service Reform Programme

It is the largest programme of change to be undertaken by the Irish Health Service since the establishment of the health boards in 1970. It sets out: a new national management structure for the health service, a reduction in the number of agencies involved in the planning and delivery of health services, new financial accountability systems and a reconfiguration of hospital services (Department of Health & Children, 2003a, 2003d, 2003e, 2004a). The main elements of the reform programme are listed in Table 6.8

Table 6.8: Main Elements of the Health Service Reform Programme

Mainstreaming, consolidation and abolition of thirty two agencies (including existing health boards and the Eastern Regional Health Authority)
Establishment of a Health Services Executive incorporating a National Hospitals Office, Primary, Community and Continuing Care Directorates and National Shared Services Centre
Restructuring of the DoH&C
Establishment of the Health Information and Quality Authority
Changes to financial accountability and improvements in financial management systems

Action committees, consisting of key stakeholders in the existing system, were established in September 2003 to contribute to the design phase of the reform

programme.³¹ In addition separate action committees were given responsibility for systems as illustrated in Table 6.9

Table 6.9: Health Management Support Systems

Financial Management and Control
Information and Communications Technology (ICT)
Communications
Human Resources and Industrials Relations
Governance

Source: DoH&C (2004a:8)

Each action committee produced recommendations for the design of structures, systems and business processes in their area of reform together with an outline of the key steps required. These have been integrated into a single report to present the “high level thinking in an integrated format, so that issues requiring decision in all phases are surfaced for attention” (Department of Health & Children, 2004a:9). Further details on the Financial Management and Control Systems are provided in section 6.9.1.

6.9.1 New Financial Management and Control Systems

The National Finance Directorate, one of the directorates of the HSE will have responsibility for the management of the health system's budget and cash management system. This involves moving from a number of different financial systems to an integrated model, which will occur over time. It will also provide strategic financial and management support to the board of the HSE and the other national directorates: primary, community and continuing care, the national hospitals office, population health, human resources, information and communication technology, shared services,

³¹ Actions committees were established on the following areas: Health Service Executive; Restructuring of the Department of Health & Children; Nationals Hospitals Office; Primary, Community and Continuing Care; Health Information and Quality Authority; Streamlining of Agencies.

change management and organizational development, corporate affairs, corporate services and communications.

The Financial Information Systems Project (FISP) is the new financial management system for the health service. It is being undertaken as one element of the Health Service Reform Programme and will provide a standardised single finance and materials management system using SAP software. It will have common business processes and operate on a national level. SAP is a system used to integrate all elements and functions across an organisation onto a single computer system that can serve all different needs. One requirement of the new financial system is that it is required to report on a cash basis and an income and expenditure (accruals) basis to meet the vote³² accounting requirements of the Department of Finance. The position prior to the HSE assuming management responsibility for the health service was that each regional health board reported on an income and expenditure basis monthly and annually to the DoH&C. The DoH&C reported to the Department of Finance on a cash basis, as the vote for health³³ was made to the DoH&C. From 2005 the vote for health is made directly to the HSE requiring the CEO of the HSE, as the Accounting Officer,³⁴ to report on a cash basis. The FISP project has encountered delays due to the necessity to alter the design principles of the new financial systems so as to accommodate vote accounting in addition to continuing to account on an accruals (income and expenditure) basis. The project is sponsored by one of the regional health boards which have been abolished (now a HSE region). The implementation management group (of 7 people) leading the project, in addition to the national project director, consists of directors of finance,

³² The vote accounting system is "a cash receipts and payments system. It is operated by [Government] Departments to provide for parliamentary control over public expenditure by ensuring that public moneys are spent legally and properly in accordance with parliamentary grants." (Department of Finance, 2004: section D).

³³ A vote is "a coherent area of government expenditure which is the responsibility of a single Government Department or Office which is in turn accountable to the Dail for the expenditure shown. A vote account is an account in the books of the Paymaster General's Office for each individual Supply Estimate approved by the Dail" (Department of Finance, 2004: section D).

³⁴ The Accounting Officer is a senior official (normally the Secretary General) in each Department or Office specially and personally charged with signing the appropriation account and accountable for the propriety of the Department's expenditure, the accuracy of the account and for prudent and economical administration (Department of Finance, 2004: section D).

directors of information services, and a regional materials manager from the ten regional health boards in the pre-HSE organisational structure.

6.10 Summary

This chapter has outlined both the historical and contemporary developments in health management that have influenced the development of hospital services, systems and structures. It will provide a background for the reader in placing each of the hospital case study sites in context. The role of the Church in health reform was significant in Ireland compared to other countries. The power of the Church, combined with the authority of the medical hospital consultant establishment, influenced the development of Irish health policy and hospitals. Fiscal conditions also shaped the present acute hospital capacity. Economic circumstances in the 1980's reduced the capacity of acute hospitals substantially as measured by the number of beds (see Table 6.5). Efficiencies have been wrung from existing bed capacity. Almost the same number of patients were seen in Irish hospitals in 2000 as in 1980 despite a 33% reduction in bed capacity. Staffing, medical technology, new drugs and some additional beds are absorbing the increasing resources invested in the acute hospitals programme, a cumulative increase of 177% since 1997.

There has been a series of reports since 1932 examining the working of the Irish health system. The Devlin Commission's findings were welcomed in 1969 but few of the recommendations were implemented. Implementation required substantial political will to alter the framework of county and district hospital provision in almost every Irish town. The Hanly Report in 2003 has made similar recommendations which have been accepted as policy by Government. Once again implementation will require substantial political will and a disregard for local constituency politics which has inhibited reforms since the foundation of the State. Since the first health strategy in 1994, the language of NPM has begun to permeate the health service. Concerns with accountability, the customer and quality have consistently appeared in successive health strategies

There is currently significant reform of healthcare and hospital structures underway in Ireland. The current status of new financial management systems has been outlined. However, the purpose of this study is to examine how well the existing financial management information system has served the needs of managers at all levels of the health service and then to examine the changes in accounting that are accompanying new public management developments throughout the health service. The issues of equity, lack of accountability and lack of clear delineation of responsibility are commonalities that have been highlighted on several occasions in this chapter. These issues have a place also in the New Public Management literature (as discussed in chapters 2 and 3) and will be examined again in the analysis of the case studies (chapters 7-10).

CHAPTER 7

ASHFORD HOSPITAL CASE STUDY

7.1 Introduction

Ashford Regional Hospital (hereafter called Ashford) operates on two sites: at Elmpark Hospital on the western edge of the city and at Crestwood on the eastern side of the city. There is a single management structure for both of these sites. The hospital general manager reports to the regional manager for acute services, at the Northern Area Health Board (hereafter called NHB) located in the city of Ashville.³⁵ This case study hospital will be examined under a number of themes that emanate from the NPM literature and that recurred in the course of the semi-structured interviews with staff at Ashford, the area health board and the DoH&C (see Table A1, A3 and A7 in Appendix A for a list of interviews relevant to the Ashford case study).

As Ashford is the largest acute hospital in the region and consumes 32.6%³⁶ of the overall area health budget, there is a close relationship between the area health board and the hospital (section 7.2). Particular tensions and difficulties were identified both by the health board and by the hospital and these are considered in this section. Having considered the health board context the study then examines issues pertinent to this case study at Ashford hospital. Sources of management information and management support at the hospital are examined (section 7.3.1). The hospital and health board finance function interface with staff at the hospital, health board and DoH&C. The capacity and limitations of the accounting and finance function is examined (section 7.3.2), followed by a critique of the support offered to staff by the accounting information system (7.3.3). The increasing importance of service planning as a resource management tool is then considered (section 7.3.4). Accountability and discretionary control (key elements of NPM) are assumed to be supported by a robust finance function and competent financial information systems. This claim is examined in the context of

³⁵ As noted in chapter 5, all names in the case studies are fictitious for reasons of confidentiality.

³⁶ Figures obtained for the Draft Service Plan 2005 submitted by the area health board to the DoH&C, October 2004 (Northern Health Board, 2004b: 1 and 192).

Ashford (section 7.3.5), followed by consideration of performance measurement (section 7.3.6). Large specialised organisations such as hospitals are staffed by people with different focuses – managerial and clinical. In chapter three it was observed that this may give rise to tensions when the objectives of these groups are misaligned. This is examined in the context of Ashford (section 7.3.7). The chapter concludes with a discussion of the findings and an explanation of the results (section 7.4).

7.2 Hospital and Health Board Interfaces

The hospital, though funded by the DoH&C, receives its allocation of funds from the area health board. The three key programmes within the NHB are: acute services and primary care, mental health and older people, and community services. Of the three programmes, acute services accounts for the biggest portion of the budget (40.5% in 2002 as detailed in Appendix E: Table E1). The NHB operates four acute hospitals, including Ashford. In the NHB service plan for 2002 these hospitals had a budget of €234 million, with Ashford as the largest acute hospital allocated the largest portion (63.1%) of the acute hospital budget (as detailed in Appendix E: Table E2). The hospital's district is in a city surrounded by a large, predominantly rural region, with a small, thinly-spread population. The area health board is sited on the opposite side of the city from Ashford.

As this is the first case study in this study, some contextual information is provided on the relationship between the NHB and Ashford Regional Hospital to provide some background for an understanding of the supports and constraints within which Ashford's management and accountants work. The NHB provides a range of support services to management at the hospital in the areas of finance, materials management, IT and personnel. Monthly accountability meetings are held by the Chief Executive Officer (hereafter CEO) of the NHB with the corporate team³⁷ at the Board at which the budgetary position, activity levels and whole time equivalent numbers of staff (hereafter

³⁷ The NHB corporate team consists of: the CEO; assistant CEOs for acute hospital care, mental health and community services and corporate and public affairs; the directors of Human Resources, Finance, and Management Services.

WTEs) are routinely tabled for discussion. At Ashford all communication intended for the area health board CEO is channelled through the hospital general manager's office or through the director of finance at the health board. Communications from clinicians intended for the NHB CEO must be made through the hospital general manager's office, whilst the hospital financial controller reports to the hospital general manager but has a dotted reporting line to the director of finance at the NHB. There is a great deal of frustration expressed by hospital financial staff and clinicians alike at not being able to give briefings directly to the CEO of the Board.

7.2.1 Tensions and Difficulties

Relationships between some clinicians and health board management are strained, in part for two reasons, firstly because of a lack of direct dialogue, and secondly because of a lack of visibility of health board management on site at Ashford on an ongoing basis. A clinician who is responsible for the consumption of a large portion of the pharmacy budget and of radiography services told of how he has only met with the CEO on one occasion since taking up a hospital consultant appointment five years ago. This reflects a lack of visibility of health board management and the development of antipathy towards management for such a 'hands-off' management approach. For example as noted by a clinician:

The health board has been a disaster. A complete barrier with no responsibility and nobody identified who would take responsibility for the state of our services.

However, NPM involves decentralisation and delegation of resources and responsibility for resource management at local levels. Is this NPM? The delegation aspect of resource management will be examined later in this case study. Clinicians and other staff interviewed in this hospital do not like this hands-off management approach. This lack of dialogue between clinicians and management staff was also referred to by staff at the DoH&C and may not be in accord with NPM ideas in this instance:

I think everything is a bit too remote and maybe we in the Department or even the health boards don't take enough account of what the problems of the hospitals actually are. ...

Assistant Secretary – DoH&C

We were in a shocking position. We spent the nineties literally just getting ourselves back standing again and then money started to come ... real proper investment started to come in 1997 but by that stage your equipment was falling asunder and to be honest we were attaching more importance to important medical equipment, than management information systems.

Assistant Principal – DoH&C

Historical harsh economic conditions continue to influence current hospital services. Several staff (clinicians and nursing staff) identified the lack of resources – personnel and poor infrastructure – as the biggest problem facing the hospital. Centralised control of staff numbers has been reasserted from December 2002. Since the 31st December 2002 tight control of staff numbers has been exercised by the DoH&C in accordance with Circular No.6/2003 issued by the DoH&C. At present, because of the WTE capping:

We are cancelling cases once, twice, three or four times because there is no bed, because the emergencies have taken over the beds. Sometimes the patient would arrive in casualty, it might be twenty four hours before they get a bed, it might be twenty four hours or forty eight hours before they get into theatre, that's three days wait before they get from the time of injury into surgery so they can go back home again. The operation may take ten, fifteen minutes. We don't have the facility to actually operate on them for those ten or fifteen minutes, to get them in and get them out again.

Clinician 3

The pressure on beds results in inefficiencies in the operation of the hospital, as clinicians of any given speciality (example: dermatology, oncology, plastic surgery) can find that their emergency admission patients are located all around the hospital. Whilst a patient may be admitted to dermatological surgery from A&E, the post operative bed available may be located at a distance from the clinical speciality unit on the hospital campus.

You could have a ward round and you could have twenty patients and they could be all over the hospital. They could be over in the Obstetrics and Gynae unit or over in Geriatrics because that is where the bed was.

Clinician 3

This also leads to difficulties in caring for patients, as for example nursing staff trained for a particular discipline, such as plastic surgery or oncology, may have to be seconded to these wards to provide appropriate care for individual patients, thus adding to inefficiencies. The alternative is that patients do not receive the same quality of care that they would receive in the specialist unit. The increase in clinical specialities creates additional pressure on resources and on staff relations at the hospital. For instance, the

size of the paediatric unit, in terms of physical infrastructure of beds, has not changed over the past twenty years, yet the number of specialties for children has grown to include urology, dermatology, plastic surgery, ear nose and throat (ENT), and ophthalmology: “Every consultant expects to get their children into the unit yet our unit is the same size as it was fifty years ago” (Clinical Nurse Manager). There is a consistent concern expressed by some clinicians about the need to be increasingly patient-centred:

We have a phlebotomy room over there, you have people for the oncology clinic who can hardly stand and it's like musical chairs. There are a few chairs, but if you sit down will you lose your place in the queue for the phlebotomist? Now that isn't big resources. I mean we talk of being patient centred but really are we? Clinician 1

The bureaucratic nature of hospital decision-making creates difficulties for staff carrying out their functions, be it nursing staff, finance staff or clinicians. It also militates against patient centred care in some instances.

Here you go from one person to another person to another person, to make a decision. It's this big paper trail and it is terrible. For example if you want to get a gown for a burns patient or something like this we spend about a month going through this paper trail whereas the garment has to be on within two or three weeks, measured, everything fitted, but until recently we used to have to go through this huge rigmarole. There are huge inefficiencies. One person should be able to make that decision. Clinician 3

This increase in bureaucracy has grown as the hospital has grown in size. The lack of discretion of management to make quick decisions has been identified as a problem by five staff interviewed. There is a concern that many decisions have to be referred to the area health board or to the Department: “We have an awful lot of talking shop meetings but the person never has the authority to make a decision in management”, (Clinician 1). NPM favours management discretion. The absence of health board management on the Ashford hospital site has not facilitated increased discretion. The perception of long serving staff is that decision-making is increasingly centred at the health board and the DoH&C.

7.3 The Case Study Setting

Ashford Regional Hospital has a bed capacity of 757, next in terms of bed capacity to St. James Hospital, Dublin which has 771 beds, and followed by Beaumont Hospital,

Dublin with 605 beds (Department of Health & Children, 2004d). More than 40% of the people in the region that Ashford Regional Hospital serves are in receipt of a medical card, compared with a national average of just under 31.5% (Northern Health Board, 2001:15). This creates additional pressure on public hospital service provision compared to that of other hospitals. Statistics on key aspects of performance are reported in Table 7.1 below.

Table 7.1: Activity Statistics for Ashford

	No. of in-patient beds available	In patient admissions	% occupancy ^{38 39}	Average length of stay (days) ⁴⁰	Day cases	Casualty attendances
1994 *	693	29,779	89.6	7.78	5,608	45,228
1997 #	708	30,573	81.8	7.03	11,468	50,011
2000 >	737	33,489	82.8	6.71	23,649	58,519
2003 +	757	not available	85.2	6.23	26,589	58,089

Source: * DoH&C (2000:148)
 # DoH&C (2003b:171)
 > DoH&C (2003b:177)
 + Information supplied by the DoH&C (2004d)

At Ashford there has been a 6.3% increase in bed capacity from 1994 to 2000, accompanied by a 12.5% increase in in-patient admissions, and a 322% increase in day case activity over this six year period. There was a 374% increase in day case activity over the nine year period to December 2003. Ashford’s average length of stay in 2000 was 6.71 days as compared to a national average of 6.6 days (Department of Health & Children, 2002:9). In 2000, bed occupancy at 82.8% was slightly below the most recent

³⁸ The “internationally recognised measure of full occupancy is 85%”, (Department of Health & Children, 2002:10).

³⁹ The data in Table 7.1 is reported separately, by the DoH&C, for the two hospital sites Elmpark and Crestwood that comprise Ashford Regional Hospital. Therefore the ‘%occupancy’ data and the ‘average length of stay’ data, as reported by the DoH&C, have been weighted for the two hospital sites in the ratio of the number of patient beds available at both sites (column 2.1, Table 7.1).

⁴⁰ See preceding footnote.

available figures for national bed occupancy of 83.3% in 2000 (Department of Health & Children, 2002:54). Despite the increased 20 beds which became available, the bed occupancy ratio three years later in 2003 was 85.2%, indicating continued efficient usage of bed capacity and increasing demands on hospital services. Changes in day case activity in Ashford can be compared to the most recent national statistics available for acute hospital activity for the year 2000. Day case activity nationally increased by 68% between 1995 and 2000 (Department of Health & Children, 2002:33), whereas day case activity at Ashford increased by 322% in the six year period 1994-2000. However the Ashford base in 1995 was low compared to other hospitals of a similar size (Deloitte & Touche, 2001a). Staff numbers have also grown at Ashford (see Table 7.2).

Table 7.2: Staffing Statistics Ashford

Year	Total Staff	Management/ Administrative Staff ⁴¹	Management Staff as a % of total staff
December 2000~	2401	282	11.7
December 2003+	2703	412	15.2
Growth in staff December 2000- 03	12.6%	46.1%	—

Source: ~ DoH&C (2001b:5 and 8)
+ DoH&C (2004b)

Between December 2000 and December 2003 the greatest relative increase has been in management staff, who have grown by 46% relative to an overall increase of 12.6% in the three year period to December 2003. However, the increase in staff numbers primarily took place in the year to December 2001. As noted by one clinician in Ashford “We have got a lot of jobs created over the last fifteen years but not in the areas

⁴¹ This category of management/administrative staff includes such staff as hospital consultants’ secretaries, community welfare officers, out-patient department personnel, ward clerks, medical records personnel, telephonists and computer personnel who are engaged in front line duties.

where it helps patient throughput”, (Clinician 3). Since December 2002 there has been a restriction on recruitment as detailed and outlined in section 7.3.1.

7.3.1 Management Information and Management Support

Three sources of information are increasingly used to manage acute hospital services at Ashford: financial information, activity information, and staff control numbers – WTEs. WTE information has grown in importance. All hospital staff are aware of its existence as a restraint on service development.

The accounting information hasn't changed, though it's coming more regularly now. Five or six years ago I had to ask for it. But the structure of what we receive hasn't changed over the years. Now the whole time equivalent and the activity reports have developed.

Director of Nursing

Hospital management information is derived from a number of sources, including the finance department and the information services department at Ashford. The monthly income and expenditure account is prepared by the hospital finance department and forwarded to the health board. It contains details of income divided into 20 categories and expenditure divided into pay (7) categories and non pay (34) categories. These classifications are stipulated by the DoH&C. Staff numbers are reported on a monthly basis in the form of WTEs by the hospital finance department. Data on staff numbers is captured and prepared manually. The Information Services Department using the Patient Administration System (PAS) extracts and reports details on admissions, discharges, day cases, bed days and sources of referral on a speciality basis to the health board. Until 1999 communication between staff was by means of memoranda. In 1999 electronic communication was made available to staff at the health board and subsequently at the hospital.

Management control at the area health board is restricted by the requirement to adhere to the WTE ceiling imposed on all services from the 31st of December 2002. This is establishment control. Prior to this date this health board had been approved for service developments and an allocation of monies was received for the year beginning 1st January 2003. However, the health board was not allowed to breach the imposed WTE ceiling in commencing these services. This was despite the new service proposal

requiring fifteen new posts for which funding was allocated but WTE numbers were not approved. The WTE capping leads to difficult decisions as money for service developments cannot be drawn down until the service commences. However, the service cannot commence without depriving some other service of existing staff to commence the new service, as the DoH&C require that the WTE ceiling cannot be breached. New developments can only go ahead at the cost of suppressing⁴² a post elsewhere. This policy of more for less is in line with Hood's (1991; 1995b) NPM doctrines. In order to circumvent the imposed WTE ceiling, the health board have been contracting out services and recruiting staff on a temporary agency basis. Staff recruited in this way do not count for WTE control purposes. However, this practice gives rise to other human relations type issues.

We have probably run into barriers there because it is a very unionised industry so obviously the unions would prefer us to directly employ more staff than contract out. So, that's very difficult. And it's quite an artificial distinction because then how do you keep a handle across the totality of the Board? Our budget would be broadly divided into pay and non-pay and within pay if there are national increments, if there is superannuation, if there are pay awards, we would tend to be funded from the Department of Health to accommodate that. Now if within your non-pay you have got this kind of contracting element which really is pay, but you are not getting the pay awards and the benchmarking and the parallel benchmarking you are storing up a problem for the future. This has happened to us before.

Assistant CEO – area health board

Allocation of money for year 200Y is made in the Letter of Determination from the DoH&C to health boards in November/December 200X. This consists of a core budget (previous year + inflation) and development monies (if any). The Letter of Determination sets out how development monies are to be spent. This letter is copied to the acute hospitals. In the 2004 Letter of Determination from the DoH&C, emphasis was once again placed on the need not only to adhere to WTE totals but also to seek a reduction in staff numbers to facilitate a reduction in public service employment levels overall.

⁴² Suppressing posts is the term used by several staff in interviews to describe the situation of “robbing Peter to pay Paul”. New service developments with a financial allocation but without a WTE allocation have presented difficulties for hospital management charged with implementing developments over the past two years 2003 and 2004.

You will be aware that the Minister for Finance indicated in his Budget Statement in December 2002 that a reduction of 5,000 is planned in the numbers employed in the public service over the period to end-2005. A further reduction of 200 posts in the national employment ceiling is to be achieved by end 2004, in respect of which the contribution of your Board will be on the same basis as the 2003 adjustment. Your service plan should take into account this further reduction in the authorised ceiling... with specific emphasis on posts that are not directly involved in the delivery of front-line services.

Letter of Determination from the Secretary General of the Department of Health and Children to the CEO of the area health board, December (2003c:9)

On occasions the director of nursing at Ashford has had to breach the WTE ceiling to provide staffing for special cases or to provide nursing support for an overcrowded Accident and Emergency department. At the point of each breach, she notifies the hospital general manager of this.

The hospital was divided into four divisions in 1997, with the intention that this would be a precursor to a clinical directorate model. In each of the divisions there is a clinical facilitator (a consultant hospital doctor), a divisional nurse manager and a staff officer, grade V. There is a meeting with the deputy general manager of the hospital, director of nursing, services manager and finance manager every second Monday morning. This group is called the Hospital Operation Management Group (HOMG). Operational issues are primarily dealt with at the HOMG. Unresolved issues of this group are forwarded to the Hospital Management Advisory Group (HMAG) from this forum. The HMAG consists of the hospital general manager, the chair and secretary of the Medical Board and the Director of Nursing.

The hospital suffers from a poorly integrated system of patient care, with bottlenecks in the system causing inefficiencies. Despite the shortage of beds, long delays are routinely reported for inpatients awaiting diagnostic tests. "We have all these people sitting around in beds waiting for two weeks for a test to be done" (Clinician 2). A large number of the increases in staff over the past ten years have been in areas not directly related to patient care. For instance, it was considered that a significant portion of nursing time on wards was spent on administrative work not directly related to patient

care. A new ward clerk grade was created to address this problem. Table F1 in Appendix F illustrates both the overall increase in staff in acute hospitals in the NHB (19%) and the increase in management staff as a percentage of total staff of the board (46.5%) between 2000 and 2003.

Whilst the hospital has benefited from a capital expenditure programme over the past six years, there may be a deficiency in the management of the additional space provided as part of the programme. Two clinicians told of how frequently there are idle theatres even though there is a backlog of surgical patients in the accident and emergency department and on waiting lists. This demand for theatre space creates friction between clinicians.

You have got theatres that are available at different times but haven't got the staff to open them up. There is not enough theatre staff to run enough emergency theatres. Then the problem is at present we have got clinicians fighting against each other. Is your case more a priority, more a priority than mine. My case is urgent I have got to go in now – well my case is waiting for three days, so all these sort of problems.

Clinician 3

However, data produced by the HIPE⁴³ system is used to manage hospital beds. The data generated by the HIPE system provides the bed manager with length of stay for individual procedures for individual consultants' case statistics. This allows him to compare the length of stay for a particular procedure for one consultant against another. Information produced by the HIPE system is then used for capacity planning and deciding on patient admissions. For example: if consultant A has an average length of stay for a prosectomy of three days, and consultant B has an average of two days, then the bed manager will consider taking in consultant B's patient and not consultant A's patient on a Wednesday as he knows that if the ward is closing on Friday, consultant A's patient won't be discharged by the weekend and this will create problems with bed capacity at the weekends.⁴⁴ The expectation, when this rationale is explained to

⁴³ HIPE is the Hospital In-Patient Enquiry system used to capture data for the casemix funding model. It is separate from the accounting function in all hospitals and is under the management of the HIPE co-ordinator.

⁴⁴ There is a mix of five-day and seven-day wards in some units in the hospital.

clinicians, is that the consultant will then audit his/her practice, and examine the reasons for the longer length of stay. Of course in some instances the reasons for the longer length of stay will be outside the consultant's control, due to factors such as emergency admissions and a greater number of elderly patients on his/her list. These factors have then to be considered as planning moves forward. The bed manager also recognises that short lengths of stay are not always desirable and can lead to readmissions. Overall the bed manager shares comparative data on procedures with clinicians and in a spirit of negotiation tries to offer flexibilities in return for them making use of the data to inform their clinical work. It is a very subjective process.

7.3.2 Financial Information Systems - Capacity and Limitations

The finance manager at the hospital reports to the director of finance at the area health board. The finance department at the health board is responsible for the maintenance of the general ledger for all the Board's hospitals. On a monthly basis, the hospital supplies information required for the preparation of the Integrated Management Report (IMR) prepared by the health board's accounting function, which is then submitted to the DoH&C. The health board has employed a financial strategy comprising of several strands to manage funding pressures. These involve in the first instance taking a top slice off the budget allocation for the forthcoming year which is transferred to a corporate contingency reserve. Value for money measures have also resulted in an increase from 12% (2000) to 14% (2004) in contractible non-pay expenditure, as services are contracted out, thus circumventing the WTE ceiling and striving to provide the same quality of service at a lower price (Northern Health Board, 2004c).

The management and development of costing systems is identified as the twelfth of thirteen responsibilities of the Board's finance function, although this is not a priority list (see Appendix G). The health board and hospital finance functions are closely related. All systems interfaces and updates are the responsibility of the health board. A substantial element of the work of the hospital finance department is centred round preparing information for inclusion in the monthly IMR. There is a difficulty for the

hospital in attempting to manage its resources efficiently given that its financial information systems are almost exclusively focused on the stewardship needs of the DoH&C. The majority of the budget of the hospitals (71.4% in 2002) is payroll costs (see Table 7.3).

Table 7.3 Ashford: Allocation of the hospital budget between pay and non-pay costs 2002⁴⁵

	€000s	%
Pay Costs	117,616	71.4
Non Pay Costs	47,125	28.6
Total	164,741	100

Source: Area Health Board (2002:7 and 9)

We use development monies to balance the books, even though it’s not allowed, because it is the only way we can balance out our finances... New services have all been opened late and we are living on that kind of borrowed money.....

Director of Finance - area health board.

Service developments are implemented without approval of complete budgets needed to provide the service. This leads to pressures in the hospital as the health board is required to break-even by the HAA 1996.

You cost out each new service development for the DoH&C. Then you get an allocation of whatever amount of money it is. You probably won’t get enough but you open the service. Then you go onto the next service. Then you go into the next year, the same thing happens.’ So that is continuing year on year on year because the system is an allocation system from the top down.

Director of Finance – area health board

⁴⁵ The figures in Table 7.3 differ from those reported in Table E2 in Appendix E due to the exclusion in Table E2 of income which acute hospitals generate from patient income, road traffic accidents, long stay patients, and sundry sales. Such income is in addition to the government allocation and is used to meet costs. For the year ended December 31st 2002, the estimate of income for Ashford Regional Hospital was €16.955 million, bringing the total budget available to meet all costs to €164.741 million.

This is reactive management to the resource constrained situation that Ashford management is confronted with, and is recognised and supported at health board level, though not considered ideal. In order to develop clinical services, this is the model that hospitals must work with.

The finance function faces special difficulties in the recruitment of suitably qualified and interested staff. Appointments must be made from a panel recruitment system known as the 'Common Recruitment Pool'.⁴⁶ This can result in a middle grade vacancy being filled by a candidate with a special interest in, for instance, human resource management and with little interest in accounting and more importantly little aptitude and an absence of skills. Time spent training such a person is wasted as they leave the accounting area as soon as a suitable vacancy becomes vacant at a higher level. In addition there have been positions left vacant in the finance department of the area health board for long periods of time (e.g. two posts vacant for nine months in 2001) due to the difficulties of filling these positions from the 'Common Recruitment Pool'.

The health board have these panels e.g. a grade V panel and say a grade IV panel. It takes quite a few months to organise these competitions and then after that you are lucky if you get someone. In the meantime these positions can be advertised as acting positions within our own health board. But people are not really attracted to an acting role and very often these 'acting' positions are not filled.

Financial accountant – area health board

At the time of interview one area health board finance manager with responsibility for a staff of eight had three staff acting in a temporary capacity. Adherence to health board recruitment policies results in recruitment of staff without appropriate levels of numeracy. Finance function managers are then saddled with people in roles that they are not suitable for, for a number of years. The result is weakened financial information systems expertise at both health and hospital to support the introduction of NPM ideas. The absolute number of staff in the finance functions in both hospital and health board may not reflect the extent of this problem. The resultant level of expertise may thus be overrated.

⁴⁶ As noted in section 6.5.1 this recruitment system provides for the filling of clerical/administrative posts at grades IV to VII by competition confined to employees of health boards, local authorities and other health and local government agencies. Grade III is the first grade for entry into the health service.

Financial systems at the board were computerised in 1992 and at the hospital subsequently. Financial knowledge and expertise within the acute hospital programme of the Board has been thin. Within the acute hospitals programme there was only one qualified accountant at Ashford, and none at the other acute hospitals, until 1998 when a second accountant was recruited for Ashford. In 2001 three accountants were recruited for the community care area of the Board's activities together with accountants for the other acute hospitals. At the health board there is a systems accountant responsible for the development of computer systems for all staff. Core difficulties experienced by staff centre around the inability of the Board's systems to interface meaningfully with each other. Information on the hospital's accounting system is not up to date, given the manual system of processing invoices. The current suite of financial systems at the Board emphasises the processing of transactions rather than provision of management information. The systems accountant recognises the reality that financial systems are archaic. According to a health board accountant, the current focus is on ensuring that "we only make payments that we are supposed to make".

The relationship between the health board finance function and the finance unit at the DoH&C is fraught with tensions over the need to achieve a break-even financial position at year end and the need to know if additional 'one-off' monies will be available at year end.

We have a game that we play with the Department. I have played the game the same as everybody else. I can't tell the Department what the real position is even though I am supposed to be reporting to them because I know they have money and I know that if I tell them we'll break even, we won't get any money. Director of Finance

You are keeping the pressure on them all the time to keep it down, keep it tight and then money comes down (from the Department of Health) at the end of the year and people are saying the whole thing is crazy. Hospital Financial Controller

The structure and operation of the finance function at both the health board and hospital have been outlined in this section. In the following section the impact of the finance

function on the work of staff in the hospital is considered together with an examination of users' opinions on the usefulness of the output of the financial information systems.

7.3.3 Financial Management Information and Support Systems – a Critique

A number of staff in the hospital's finance department are responsible for reporting on WTEs on a monthly basis by grade. This is a manual system that requires data capture on paper which is then input to produce the report. The manual system is deemed necessary due to poor tracking of staff moving between departments. Also there is a difficulty extracting information on WTEs from the computerised payroll system due to different pay periods for different staff. Some staff are paid fortnightly, others four weekly and others on a calendar month basis. Both accountants at the hospital are frustrated with the archaic financial information systems. To produce any management report involves: "Taking figures out of the general ledger (which is updated twice monthly) and inputting these on Excel" (Management Accountant).

The deficiencies of both the Board's financial information system and the hospital's information system, which is primarily intended to meet the Board's financial information reporting requirements under the Health Act 1970⁴⁷, are recognised by all staff:

- | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|
| This system is inflexible and ancient. | Director of Finance |
| The information I have is that I spent X on consumables and for my department everything is lumped under consumables and the accuracy of the financial information is doubtful. That is through no fault of people, it's a poor system. | |
| | Clinician 1 |
| I keep saying I need more useful information. | Clinician 2 |
| They don't tell us how much we cost, the Department of Surgery. | Clinician 3 |
| The system is unchangeable and we are always told it can't be changed in case we lose it altogether. | |
| | Clinician 3 |

The weak financial system indicates gives an indication of the quality of information available for management decision-making. The poor quality of the financial

⁴⁷ The health boards were set up under the Health Act 1970.

information received by staff creates distrust in management as long serving staff listen repeatedly and with growing scepticism to arguments that the system is at fault and cannot be changed.

I am convinced now, and maybe I am wrong, that it suited people to have the system muddled, because money can move from one place to another. I mean I haven't a clue what comes in here and goes out, it just isn't making sense. But I am too busy to keep chasing it and I think I have been talking about this with finance people for maybe six years and they will tell you they can't do much about it. Clinician 1

Clinical staff – consultant hospital doctors, nurses, and allied health professionals – responsible for large budgets and large numbers of staff, are interested in receiving financial information about their service, but the accounting system does not have the capacity to deliver. Hospital staff have little idea of the budget assigned for their areas.

I would like to be able to judge where the money is going in my service, and where it differed to last year. I mean I get this gobbledegook that's it. They (finance staff) told me that what I was looking for was too high a degree of drilling down, that our systems couldn't support it. Clinician 1

We don't receive any information on how much our department costs specifically. It's mostly to do with budget overruns in the hospital, and it's in a way for them to defend cutbacks. So they tell us how much we've overrun, but we don't know on what, just that we've got to pull up on this or stop this or not to do this or whatever. That's the only information that we get. Clinician 3

I would like to receive more user friendly financial reports. If you get volumes produced you are not going to read any of it, whereas if you got something that you really found was pertinent to you and to your own bits and to your stakeholders also you would read it. Director of Nursing

Yet other clinicians consider that it is not worthwhile knowing about the financial costs of one's services unless one is empowered to control activity, costs and spending.

I have no idea what the budget is for my service. I would like to know. There is a complete disconnect between the requirements of my service and the budget. But I also think that there is no point in having a financial report unless you have got control over it. There is no point in knowing the nitty gritty, it's only an extra burden on you, unless you can do something about it. It's not worth having. Clinician 2

Some clinical staff have an appreciation of the need for appropriate financial information, in order to manage costs.

We have no way of actually saying that this amount of activity costs €X. All we can say at the moment is the overall figure costs €X. To me until you have something in place like that you actually can't control your spending, because you don't know what you are spending it on. Radiography Services Manager

One reason for the poor development of financial information systems is the lack of political will to invest in something that does not directly have a clear correlation with receiving additional votes at the next general election. The nature of decision-making vis-à-vis health at national level reflects in part the concerns of politicians at local level in announcing good news such as service developments, and the lack of concern with developing a financial systems infrastructure that will provide information to better manage increasing resources directed at hospital services. The existence of majority political representation on boards militates against the principles of NPM. Local constituency politics is strong in Ireland.

There had been no investment in systems since forever because no Minister wants to put any money into systems if he can open a wing of a hospital. It's much more politically sound to open a new wing or a new hospital or buy a CAT scan.

Assistant Secretary – DoH&C

Current financial information systems cannot provide assurances about value for money spent on acute hospital services. Therefore in 2001 the DoH&C commissioned a report to evaluate the position.

Currently our information with regard to arguing our case with the Department of Finance is not good. We are managing budget-wise very well. We know we are getting value for money because we have reports telling us we are getting value for money but we had to get a report done by Deloitte & Touche to tell us we were getting value for money, it's not transparent from our own systems.

Assistant Secretary – DoH&C

The repercussion for exceeding the health board budget allocation in any one year is a deduction from the following year's financial allocation to the Board. In the event that the hospital overruns its budget, this may be balanced out by unspent monies elsewhere – either in the other acute hospitals (which is unlikely) or in other areas of the Board's programmes, such as mental health or services for older people. However, only on one occasion has the Board and Ashford had a financial overrun at year end and had to incur the penalty. On all other occasions since the "accountability legislation" was introduced, the health board has "bailed the hospital out" towards the end of the financial year.⁴⁸ This process undermines the work of the hospital finance department who endeavour to highlight cost overruns from the beginning of the year and encourage

⁴⁸ These are terms used by the Hospital Finance Manager.

cost centre managers to reduce/contain costs. It appears at year end that the finance manager has:

been over reacting and shouting about nothing [as he] ... advising others to rein in spending and control budgets or else fear that the current year's deficit must come off next year's budget.

Hospital Finance Manager

This practice of additional discretionary monies at year end undermines the finance manager and leads to a disregard of management control.

Sometimes people say you are about to run out of money in September, I don't get a bit excited. There was a time I might have got worried. Clinician 1

In December for the past five years, additional monies became available. Health board finance staff ask the DoH&C repeatedly if there will be additional monies allocated to the health board late in the current year. The answer right up to December has consistently been 'no'. Yet additional discretionary money (ranging from three to seventeen million euro) has been allocated in the twelfth month of the calendar year. This creates credibility problems not just for hospital management and finance staff but also for health board management.

In October you are saying its looking like you are going to have a two million deficit and do we need to tighten the belt? Then all this money comes down. You turn around at the end of January and realise you have five million over and you feel like an idiot, a complete idiot. So what we try and do is have the tenders in for minor pieces of equipment. Where there is a genuine need it is great to be able to pick up on them and that is what we are doing at the moment. I mean last week (fourth week in November) I got word that there's 3.3 million, spend it.

Assistant CEO – area health board

Resource management is difficult in the context of shortage of theatre space and shortage of hospital beds. Whilst all acute hospitals have a bed manager in situ, there are clinical demands on beds that create difficulties for effective bed management. Inequitable use of beds by clinicians also creates tension among clinicians leading to a sense of disempowerment.

He who shouts loudest will be heard. There are people who will be very forceful to get patients in. There will be people who ring fence their beds – you are not going to touch our beds, we are full – and that still arises. When a patient leaves a bed, they (a consultant) ring fence their beds in their own area and it's not playing the game. If a patient needs a bed, they should go into the first available bed. That is our agreed policy. But people can and sometimes have the power to ring fence their beds. Bed management or hospital management may not be strong enough to overrule some

clinicians. So if you bully your way along, you will get your patients in. If you don't bully, you won't get your patients in.

Clinician 3

There is evidence here of a break-down in the clinicians' world and the emergence of a crisis as to how best to manage resources. Hospital management do not have the tools and system supports to address the question of the best management of clinical resources.

Bed management of private and public patients is operated in accordance with the Health (Amendment) Act 1991⁴⁹ with considerable necessary discretion on the part of the bed manager. Private patients are booked in via consultants' private secretaries. The bed manager looks at the number of patients (both public and private) a consultant has in the hospital at any one time. The bed management department keeps a 24 hour list. The number of private and public patients under a consultant is examined, together with their method of entry to the hospital. If for example a consultant has 50% private and 50% public patients when his patient statistics are examined, it is recognised that he/she can't control the 50% private patients that were admitted as emergencies directly from the A&E Department.

In the real world if we were in economics I would be saying to that consultant 'right you have over stepped your mark with the amount of private emergencies that you have. Therefore for the next two months you can't have elective patients into the hospital' but I can't do that. That's inequality to all patients. So there are huge difficulties in managing the public/private mix of this hospital. I operate more by negotiation – 'if your private patient gets in, then two publics that are on the waiting list for four months, you'll take them in next week, will you?' I find that this works best.

Hospital Bed Manager

The lack of financial information to assist with the best use of resources combined with the difficulty of assigning not only beds but theatre space for public and private patients makes the management of Irish hospitals particularly difficult. At present management of waiting lists is a subjective process whereby bed managers try to reach agreement with clinicians to book patients in for procedures, when they foresee bed capacity to accommodate them.

⁴⁹ As noted in chapter 6, this legislation requires the hospital to report on adherence to the 20/80 private / public bed designation occupancy.

We (the waiting list co-ordinator and myself) look at the waiting lists and then we contact the consultants and tell them that we have Mary and Johnny who are waiting for a certain period of time, they are on your list, we have beds at the moment, you have a theatre list in three days time, would it be ok to take these patients in and get them off the waiting list?

Hospital Bed Manager

What the present control system with its non-negotiable WTE capping does not allow for is that increasing staff numbers can have benefits in particular areas. Yet it is almost impossible to get the DoH&C to concede an additional WTEs despite local attempts to make savings. Discretion is being eroded on Value for Money areas such as this, areas that were being promoted two years previously. Example:

There are huge pressure to put in nurses and doctors and physiotherapists and occupational therapists and to some extent rightly so. But I don't think it recognises how much the supporting structure was under developed and there are costs to such an approach. We know that if we can put in a pharmacy technician, that person will save their salary twice over and by not putting them in, its poor value for money.

Assistant CEO – area health board

Tight control exercised from the centre (the DoH&C and the Department of Finance) results in inefficiencies and waste in the system. In some instances, staff are encouraged to work overtime, even though they are not interested in additional hours. This, however, is one way to circumvent the WTE control even though it has implications for productivity, and overtime costs are a further burden on the system and are counter productive. This centralised form of bureaucratic control is counter to NPM values. There is little delegation of resource management. Where there is, there are inadequate financial systems to support decision-making in the context of the best use of resources. Centralised management undermines the efficiency of service delivery. Against this centralised current is the counterforce of decentralised planning of hospital activity required by the HAA 1996.

7.3.4 The Service Planning Process

Under the HAA 1996 it is the responsibility of the health board to operate within their agreed operating budget for the year. This responsibility to operate within budget is then passed down through the three programmes of the Board (acute services and primary care, mental health and services for older people, and community services). It is the responsibility of the management accounting function at the NHB to co-ordinate this

budgetary / service planning process. The management team at the area health board allocate the funding in the Letter of Determination to the three programmes. Any specific funding highlighted in the Letter of Determination is allocated to the relevant programme. The primary determinant of the current year’s budget will be last year’s revised adjusted budget.⁵⁰ The annual budgetary process does not directly link forecasted activity and level of service with the funding received. Table 7.4 illustrates the final phase of the annual budgetary process at Ashford since the enactment of the ‘accountability legislation’. Once the Ashford budget has been agreed it is then allocated in the hospital to cost centres based on last year’s expenditure. This allocation is carried out by the finance department at Ashford. Cost centre budget holders within the hospital are not involved in this allocation process. Again the annual budget is not allocated based on forecast activity within the hospital.

Table 7.4 Model of annual budgetary process at Ashford

Date	Activity	Responsibility
Dec xx	Letter of Determination	Secretary general, DoH&C
Dec xx	Meetings	Health board and hospital management
Jan yy	Service Plan agreed	Health board and hospital management
Jan yy	At hospital budget is allocated to cost centres	Finance department at hospital

The current allocation system, which is centred on the National Annual Estimates and Budgetary Cycle⁵¹ is seen as inflexible and uncertain (Department of Health & Children, 2001a:52). The Board has 42 days to submit a service plan to comply with the HAA 1996 referred to within the health sector as “the accountability legislation” and discussed

⁵⁰ The previous year’s revised adjusted budget is the original budget allocated last year, adjusted for any additional development monies allocated during the previous year.

⁵¹ The Annual Estimates and Budgetary Cycle is the government’s financial budgeting exercise which determines on an annual basis the monies available for each public service. The perceived inflexibility and uncertainty of the current allocation system, which is centred on this annual Estimates and Budgetary cycle, was raised in submissions to the DoH&C, in its preparation of the most recent health strategy “Quality and Fairness – a Health System for You”, as a weakness of the current funding model. It militates against longer-term planning (Department of Health & Children, 2001a:54).

earlier in chapter 6. The service planning process for 2002 is described in Table 7.5. The Health Service Executive (HSE) has brought forward the time for completion of the 2005 service plan for core funding to October 15th 2004. However, the HSE first National Service Plan for the health service was not published until April 2005. The purpose of the Service Plan is to act as a benchmark against which expenditure, output and progress will be assessed.

Table 7.5 Service Planning Process for 2002

Month	Meetings	Objective
March – May 2001 Meeting 1	Meetings commence with various care groups (20) (see Appendix H) Care groups comprised of following staff: Nursing, paramedical, consultants, others General manager or deputy general manager attends with Grade VII clerical support The finance manager or management accountant also attends	To examine core activities and to identify the additional activities that the department would like to engage in during the next year Accountant places cost on “wishes” of the care group
June – August 2001 Meeting 2	Care group present ‘wish list’, identifying priorities supported by costings to the general manager	General manager to assess priorities for inclusion in service plan
December 2001 – January 2002 Meeting 3	Post Budget and Letter of Determination General manager and finance manager or management accountant	To tell each group of the outcome of their involvement in the service planning process

Source: Interviews

The third and final meeting (noted in Table 7.5) at the end of the service planning process has been described as difficult by the hospital finance manager.

Then post Budget and Letter of Determination, we met with them (care groups) again to tell them that they all got nothing. They came up with all their priorities, spent a lot of time doing it and there was no money for anything. Hospital Finance Manager

There has been some limited involvement of 'clinicians in management' through the care groups that have been identified for service planning purposes (see Appendix H). One difficulty in engaging 'clinicians in management' was the clinicians concern with an inadequate budget.

They considered that Ashford seemed to be always overspent. Clinicians decided that they were not taking responsibility for a hospital budget – or the individual parts that make up the hospital budget – when we're always over-extended.

Management Accountant

Even within the finance department it is considered that there is minimal benefit to clinicians from the service planning process. "If we were to look at the service plan and ask 'what does the department take from that service plan?' I would say very very little", (Management Accountant). The finance manager and management accountant who initiated the service planning process in 2001 for 2002 also felt let down by the outcome.

It is very very difficult to ask these people to be involved again next year. Some areas did not get a penny, not a single thing after doing the service plan. I remember the general manager saying after one meeting 'I'm not doing this again'. That's exactly how we felt, when we saw the Letter of Determination. Only for the casemix⁵² money, we said what is the point?

Management Accountant

The service planning process is seen as futile by the clinicians interviewed.

I have written a service plan year on year that is never funded. It is a pointless exercise. It is condensed and put together with the other service plans from groups in the hospital. They (hospital management) send it in (to the health board) and it is shortened further. It reads like a work of fiction. I mean basically it is achievements of the last year, most of the time it's nil, but things have to be put down there. Then there would be priorities for next year but in fact because priorities are now five years old, you can't discriminate between priorities and it's a charade. I would have to tell you I have submitted almost the same service plan for the previous years because none of what we have put into the service plan generally is funded. Clinician 2

We always put in what we think we need, but there is only one minor problem, you never get it.

Clinician 1

Service planning is a paper exercise that you do once a year. The clinicians were here for the service planning meeting again this year, even though they are disillusioned by not getting any development in services over the past five years.

Clinical Nurse Manager

⁵² This hospital has been a net beneficiary of a positive casemix adjustment for several years. This is the largest amount of discretionary money available to hospital management. Given that all core funding and development monies have labels attached, this discretionary money allows hospital management some discretion in funding initiatives at hospital level.

It's an exercise. You don't see anything from the work you do in putting it in, you don't see anything coming out. Yet if you don't put it in, you will get nothing at all. You might even be worse off in a sense. But it's not a great exercise.

Clinician 3

Yet senior staff at the Department recognise the need for having clinicians involved in the service planning process: "Unless you get clinicians involved ...you are not going to get proper service planning in the acute hospital setting" (Assistant Secretary – DoH&C).

Senior staff at the Department meet the CEO of each health board quarterly to discuss progress on implementation of the service plan. In addition the Minister for Health and Children meets the CEO group mid year to discuss progress.

The agenda for each of these meetings is the Service Plan. The service plan therefore has become a very obvious and highly transparent system for managing the health services.

Assistant Secretary – DoH&C

There are some good outcomes of the service planning process: clinicians who have involved themselves in service planning increasingly understand the pressure on resources. Service departments such as laboratories and radiology attend service plan meetings across a wide number of care groups. In these cases, clinicians observed how difficult it was to argue for resources for one's service when they hear the basic requests for necessary equipment put forward by other departments.

You are competing with very genuine needs in other sections, many of which would have an interface with the public. So you have to persuade the general manager that your items are worthy of mention to get into the Ashford service plan.If you have got ICU (Intensive Care Unit) beds that need a new monitor or something, it's very hard to argue that that isn't a necessity, if it's a new incubator for PPU.

Clinician 1

Yet clinicians continue to involve themselves in the service planning process, fearing that if they do not that they will not get any additional resources at all. As nursing staff have engaged in the service planning process and work in all clinical units in the hospital, this has assisted in disseminating the service planning message. There is an increasing emphasis on the requirement to examine core service plan funding at unit level and reconsider how work is carried out so as to make the best use of that money. Nursing staff consider that the consultation and communication process involved in

service planning has benefits: the fact that the communication is ongoing makes people feel better and it changes their attitudes and makes them feel part of the system.

It (service planning) is the bible really of the hospital. For example: if one of the ward sisters says we want to get an extra nurse for whatever, well I'd say have you got it in your service plan? If they say no, then I'd say we are not going to get it this year then, but if you think it's a priority let's put it in for next year.

Director of Nursing

The WTE capping presents difficulties for those responsible for service planning, in the sense that if something is not in the service plan it will not be resourced. For example, the radiography department are aware that two new cardiologists are being appointed to Ashford. The two existing radiographers assigned to cardiology are working in a situation where the work load will increased three fold. Yet the radiography department are told to plan for services knowing there are two new cardiologists starting but not to expect any new WTEs. The radiography services manager sees such advice as counter productive. He knows that he is operating in a context that if it is not in the service plan and you seek additional staff during the year - you are told: "it wasn't in the service plan, so no".

The foregoing views and opinions on the value of the service planning process do not coincide with the views expressed by staff at the DoH&C.

The introduction of service planning and management reporting and the accountability legislation with the first charge has been the single biggest issue that has allowed budgetary management.

Assistant Principal – DoH&C

There's a strategic framework there now, which I think works very well. Service planning is a very, very serious issue in the health service.

Assistant Secretary – DoH&C

Yet this does not concur with views of staff who deliver health services in this acute hospital and who are responsible for part of the health budget. Service planning has failed in its attempt to make a clear connection between services delivered and funding approved. This failure and discrepancy in the views of hospital staff and DoH&C staff requires addressing on the part of the new management authority charged with management of the overall health service – the Health Service Executive.

7.3.5 Accountability and Control

A further anomaly of attempts to engage 'clinicians in management' is that whilst the clinician is allowed a reduction in the number of clinical sessions required under his/her contract to facilitate their involvement in management, the lost clinical sessions are not funded.

If you are dragging me off to a meeting midway through the afternoon, people aren't being seen and aren't being looked after. So unless somebody is appointed for those (clinical) sessions, clinicians in management doesn't make any sense. Clinicians should be in clinics really, first, management second. Clinician 2

A consistent part of the story in this and the other hospitals is that clinicians see accountability as closely linked to their clinical activity.

We are meticulous in our management of oncology drugs. We can evaluate for every single wastage, every dose change, every alteration. We are routinely told that we are way over in terms of cost of drugs but we can account for this. Clinician 2

Clinicians see the focus on accountability as being increasingly one directional. Some consider that the existing accounting systems lead to a lack of visibility about the resources assigned for a particular service.

I would like to know what the allocation from the Department of Health is for this service. I would like to know exactly where that budget is spent within this system. I have no idea, there is no accountability to me for what has happened to that money. Clinician 2

Some clinicians are willing to be held increasingly accountable for the financial allocation assigned to their service, provided that they can manage this allocation with the help of highly qualified staff with business skills and commercial experience.

We need to bring in the right people to do that and have direct responsibility. It has to be more of a clinical control than a managerial control because at the end of the day it's the patient we are looking after. We have to then adjust the finances to that patient getting the maximum treatment, the best treatment in the shortest period of time. I would much prefer to have someone in my area, somebody who has come directly out of the Radisson Hotel for example where they have been managing beds and charging people coming and going. Clinician 3

Clinicians are not resistant to the idea of greater responsibility in this hospital but they recognised the frailty of the hospital accounting systems and do not want to engage in the absence of relevant and timely financial information. The Director of Nursing considers it vitally important that clinicians are involved in management, as she believes that "they are the key to keeping the show on the road". She considers that the selection

of good business managers is critical to the success of a clinical directorate model proposed for the hospital, noting that: "If we don't get good business managers you can forget about it" (Director of Nursing).

There has been a sea change in the approach to accountability in the nursing area, an area that is responsible for more than half of all the staff employed in the hospital. The director of nursing noted that as her training had been with nuns in a voluntary hospital, she was always conscious of the need for efficiency and stringency in resource use. The control focus is evident in a daily focus on WTE controls.

In 1990 we didn't give feedback on how we were doing on a weekly basis, we didn't make any returns and I didn't know what accountability was, now that's a bit of an exaggeration. But there was no emphasis on it. Now I am watching my figures like a hawk.

Director of Nursing

Whilst there is great concern with WTE controls and hence control of the pay budget, there is less of a focus on the non-pay budget, in part because there is a lack of ownership due to central control of all budgets.

If I was managing it I would be totally different about how it's spent. So at the minute whether I manage within or whether I don't, it really doesn't make any difference.

Clinical Nurse Manager

A key problem with control of resources is the current lack of involvement of consultants in the control process. As the finance manager said:

Consultants are obliged as part of their contracts to plan hospital services and procedures but the control element is missing. When this is highlighted to them they say this is not in my contract. ... It is therefore left to the administrators to control.

Hospital Finance Manager

This anomaly heightens the difficulty for hospital management in implementing NPM ideas. The hospital management accountant recognises the difficulty in engaging clinicians, given the poor information systems. He is critical of the inability of the archaic accounting system to generate useful financial information.

There is no point in having them on board if we don't give them any informationor if it's not relevant or it's not accurate. They have to be able to look at the information they are getting and drill down and see exactly where they are. So the systems are very important.

Management Accountant

The present system of management is as depicted in Figure 7.1

Figure 7.1: The Management System at Ashford

Plan	Implement	Control
(Consultants and other staff, overruled by health board)	(Consultant-led service delivery)	(Administrators/Managers)

One reason advanced for the failure to develop better accountability systems is the pace at which developments have happened as additional monies have been invested in the health service after years of stringency and cut backs in the 1980’s and early 1990’s.

The focus on change and the drive for change has been delayed because of all the funding that has been available in the past couple of years, the country has been doing well. I think that if things were tighter that there would be an even greater focus on accountability.

Director of Finance

Whilst a concern with improving clinical services has been uppermost in the minds of staff at the DoH&C, the health boards and the hospital, the need for financial information systems to manage the increased investment (177% increase 1997 to 2004, see Table 6.3) has been overlooked, partly from a lack of political will at national and local level. The concern at local health board level tends to be with maximising resources at this level for the region.

Managerial accountability has also been forced on the health boards through the Public Accounts Committee.⁵³ This health board has been called before the Public Accounts Committee on three occasions since the HAA 1996. In advance of meeting the health board group the Public Accounts Committee is briefed by the Comptroller and Auditor General.

⁵³ The PAC plays an important role in accountability cycle for government spending. Funds are voted by the Oireachtas at the request of the Government, spent by Departments and State agencies, audited and reported on to the Dail by the Comptroller and Auditor General. It is these reports that are examined by the PAC. The PAC then makes its own report to the Dail and this leads to a formal reply from the Minister for Finance, known as the Minute of the Minister for Finance on the Report of the PAC (Fine Gael, 2004).

7.3.6 Performance Measurement

Performance measurement is a key element of NPM (see chapter 3). The paediatric unit at Ashford have participated in a pilot performance management project since late 2003. This is one of fourteen pilot sites throughout the health service and only one of two in acute hospital clinical units nationally. These projects were developed by the DoH&C and the Health Service Employers Agency⁵⁴ in consultation with the Health Services National Partnership Forum⁵⁵. Initially the project group was set up and a steering committee formed by the hospital human resource management department. It consisted of the senior line managers for the different disciplines working in the paediatric unit – nurses, physiotherapists, dieticians, etc. However it was soon recognised that in order to facilitate change at unit level, the people from each discipline working within the unit and delivering the service to patients should be involved.

The line managers, they weren't going to be the ones on the floor dealing with the day-to-day issues, and that was what the whole performance management thing was about. It is people on the ground who need to be involved, this soon became obvious. Now it consists of a good working group of about eleven from the unit.

Clinical Nurse Manager

The group was reformed and included allied health professionals providing services on the unit, staff working on the unit from nurse support services – a ward clerk, a representative from the domestic/kitchen staff, several staff nurses (the most junior post-qualification grade), and one clinical nurse manager. After consulting both the Service Plan for 2004, the Accreditation Quality Improvement Plan for the unit, and meeting with staff from the hospital general manager's office to identify action points relating to customer service under Sustaining Progress⁵⁶ a project was identified and agreed upon

⁵⁴ The Health Service Employers Agency (HSEA) is a representative body for health service employers. A statutory agency, it promotes the development of improved human resource practices within the health service.

⁵⁵ The Health Service National Partnership Forum (HSNPF) is a joint management / trade union steering committee for workplace partnership in the Irish health service. It was established in 1999 on foot of the provisions of Partnership 2000, the national agreement on social partnership then in place. Its primary purpose is to provide a national level forum within which health service management and trade unions can agree the broad parameters within which workplace partnership is advanced at regional and local level.

⁵⁶ Sustaining Progress is the sixth in a series of national agreements between Government and the social partners, dating back to 1987, and will run for a 3 year period between 2003 and 2005.

by the group. One of the stated project objectives identified was to develop a learning culture within the unit, an objective which would outlive the project. Communication of progress on the project included individual letters to all staff on the unit initially explaining the project and inviting staff to attend a number of information sessions. It was envisaged that post project this group might be the genesis of a mixed team accreditation group. At present:

We have difficulty getting staff on board for the accreditation and we haven't got a mixed team on the accreditation which we should have. Clinical Nurse Manager

The accreditation process gave us a focus. We had to look at the standards, we had to score ourselves and we had to say well right we're not good at this or we need to improve on the way we do that. Clinical Nurse Manager

One element of performance measurement is value-for-money (VFM). A VFM assessment of acute hospitals can be measured by activities or by outcomes (Deloitte & Touche, 2001b). On the basis of activity measures the Irish system appears to offer value for money in that hospitals are heavily utilised, broadly across the system (Deloitte & Touche, 2001b). However, some clinicians consider that some forms of performance measurement, for instance patient satisfaction surveys, detract from identifying the impediments to efficient patient through-flow.

Patients may judge their hospital stay on whether somebody was nice to them, on whether the room was clean, on whether the curtains looked nice. That doesn't reflect the medical treatment you are getting or whether you got the right medication or not. Would we be better off putting in good patient identity systems, so that when I come along to take your blood you have a positive identification and I have a handheld computer that prints out the label and when I come along in the evening to give you your medication again up comes my screen telling me you are on so much Dioxin and that's what I give you. But the patient wouldn't be impressed with that. Clinician 1

There is a concern among some clinicians also that the development of performance measures relating to hotel type hospital accommodation issues may detract from core hospital objectives. It may channel resources into non clinically efficient areas.

We need to look at extremely simple flow-diagrams of patients moving through the system and to mark where the blockages are. All this is available in industry. Clinician 1

There is criticism that performance measures in the service plan only relate to management of the service and do not consider clinical outcomes, information which may be of interest to patients.

We have outcome measures in terms of we know what our survivals are for all of our patients who have come through with all the various stages of the disease. Now all of that really relates to data that we have collected ourselves. So all of these performance measures have been driven by myself or by other clinical people in the service in an effort to see how well we are actually doing.But none of these go into the service plan.

Clinician 2

At health board level (until 31st December 2004, when the health boards were abolished) the corporate⁵⁷ team operated a performance management system. Four objectives were agreed, providing a focus for performance management: two corporate, and two functional area objectives, e.g. faster debt collection in the finance area. Health board CEOs agreed nationally what the corporate objectives were to be, and there were financial rewards for achievement. The people on the executive management team could and did get bonuses each year since it started. The figures are not published nationally, so it is not a league table.

Within acute hospitals, a key driver of performance measurement is the National Hospitals Accreditation Process. Ashford (one of the first hospitals nationally to seek accreditation) applied for accreditation in March 2001, was surveyed in October 2002 and granted advanced pre-accreditation status. They will be the subject of a second survey in October 2005. This has led to a new focus on performance measures across the hospital.

We are measuring all the time. We are looking at our re-admissions, at infection, at lengths of stay.... We are constantly looking at how we can improve things. The engine for that has been the accreditation process.

Director of Nursing

The national partnership process, which considers sectoral strategies as part of its work, continues to focus on the most recent national health strategy, Quality and Fairness – a Health System for You, in pushing forward value-for-money projects.

Value-for-money ideas mainly come from our partnership forum. We have different partnership forums, we have a nurses forum and then we have a partnership forum where we have all the staff represented. Savings are not passed directly to us but I make sure that we get some benefit if my staff save money that otherwise would not have been saved.

Director of Nursing

⁵⁷ See footnote 37 for a description of the corporate team.

Staff have engaged in targeted initiatives to reduce waiting lists, one of the most frequently discussed performance measures of acute hospitals. There was a waiting list for ENT (ear, nose and throat) and for plastic surgery for children at the hospital which was reduced with the cooperation of clinicians, nursing, theatre staff and support staff. Extra theatre sessions were scheduled and theatres also ran on Saturdays. Finance was supplied through the National Treatment Purchase Fund.⁵⁸ Where work was done within the hospital the funding was not given to the individual clinician but went to the hospital department or unit. In some instances a particularly expensive piece of equipment was purchased, in others an area was refurbished using the National Treatment Purchase Fund monies. In this way the service benefited the clinical unit. Where patients were seen at the local private hospital, clinicians (primarily consultants employed by Ashford) were remunerated on a pay per procedure basis for their time.

There are tensions for management charged with implementing DoH&C policy and striving to adhere to the HAA 1996, to deliver an agreed service within approved budget limits.

I find itit's a funny business. If I was running a hotel, and I had ninety two per cent occupancy, that would not be so dreadful. But because I am running a hospital with ninety-two per cent occupancy, I am blowing my budget. There is a lot of efficiency in there to achieve that ninety two per cent occupancy but I am a bad manager because I am allowing that to happen and to me it's like there is a contradiction in there or a real conflict.

Assistant CEO – area health board

Reference to political influence threads its way through several interviews. The presence of watchful politicians on health boards militated against rational decision-making and the most effective use of resources. Clinicians are aware of this and health board management also acknowledged that it presented them with difficulties.

The CEO is only interested in good news. Clinician 1

There is a constant dilemma of squaring the circle and the political influence is always there. On the one hand one needs to recognise that this is not a business like making

⁵⁸ The National Treatment Purchase Fund (NTPF) was established in April 2002 with the objective of reducing long term waiting lists. It is targeted at adults who are waiting a year or longer for an operation and children who are waiting six months or more for an operation. The NTPF sources treatment for qualifying patients in Ireland, Northern Ireland and the UK.

widgits. If we were truly to stay within our WTE ceiling, to stay within budget and to do the activity that we can truly afford, there would be very hard decisions to be made.

Assistant CEO – area health board

After the Letter of Determination there is a great deal of lobbying from each location to be allocated some of the discretionary money. Because of the presence of politicians on the health boards there is a great deal of political pressure on the allocation of resources.

Financial Accountant – area health board

In 2001 the DoH&C commissioned consultants to examine value for money in the health service, as existing management information systems could not reliably tell what value was being extracted from the system. The report (which remains unpublished) notes that the political nature of health boards is a constraint to the delivery of best value for money and adversely restricts decision-making. The report was also critical of senior management within boards, noting that many of the managers had grown up with the health board system since their formation under the Health Act 1970.

Despite attempts to engage ‘clinicians in management’ and to seek greater accountability, control and performance measurement, there are problems particular to acute hospitals, not in evidence in other large differentiated organisations. Among these are the differing goals and objectives of clinicians and managers. In previous studies of hospital management, clinicians were accepting of the need for them to become involved in hospital management, see Kurunmaki, Lapsley & Melia (2003) and Kurunmaki (2004). In these studies clinicians were willing to accept greater financial involvement and responsibility. This is in contrast to the position of clinicians in other studies – Abernethy & Stoelwinder (1995) and Jones & Dewing (1997). This professional managerial element of the accountability reforms is considered below.

7.3.7 Professional and Management Tensions

Some clinicians are concerned that attempts to engage them in management are simply attempts to subsequently blame them when budgets are exceeded. The issue of blame arose in the case of an interview with another clinician concerned about blame resulting from management pressure to conserve resources.

If you start with an under resourced department, is it just going to be a blame game?

Every day nearly there is an urgent e-mail out asking 'could people discharge patients?' Do we look at how many of them come back in when they have been discharged too soon? And yet who is to blame then if anything goes wrong, is it the doctor for discharging the person too soon, even though he has been pressurised by the people down in A&E to try and get beds.

Clinician 1

This links back to the views expressed by the hospital management accountant about reasons for the delay in engaging 'clinicians in management'. Yet staff at the DoH&C consider that there are some clinicians who won't engage simply because they want to retain the large degree of clinical freedom they have. This may well be the case, but was not a view expressed by clinicians in this study. The view expressed in this hospital concerned the value of involvement in what clinicians consider a less than useful process. Where is the usefulness in attending management meetings to discuss overruns in budgets where activity is demand-led?

If I were to act on the information given to me that I am over budget either I would have to stop treating patients literally in the middle of a course of treatment, or I would have to stop seeing any new patients, but then we as doctors effectively deny everything that we should be doing. So the most important thing we do is to not stop treating patients but keep treating them because our next year's budget is driven by last year's budget and so if we stop, all we do is get less next year.

Clinician 3

I typically would meet with the general manager on occasions to be told that we are over budget by X, and what can we do? I would say to him – here is your choice: either you can tell the patients to go away or you can tell them to stop getting cancer. They are the only options. It is your choice. But I can't accept responsibility for the burden of cancer in the community and the lack of services to deal with it. Completely pointless meetings.

Clinician 2

Clinicians consider that management are so tightly focused on remaining within budget that they are not concerned with quality of service.

What does not get rewarded is delivering a quality service or improving standards of care, that never gets rewarded, because that's a cost. If there is an increase in outlay, irrespective of the benefit of that increase in outlay, that is seen as a bad thing by hospital and the health board.

Clinician 2

Some consultants consider that they do not have the control management believe they have, as they are unable to effect changes to their service. They view lengthening waiting lists with frustration.

There are loads of ways that we think we can develop our service, make it far more cost effective but we don't have the power to be able to do that. We have no power at all.

Clinician 3

They (hospital and health board management) try to keep your service within what they are getting paid for. There are two thousand patients waiting to be seen. And half of these patients are waiting ten years to be seen. The Department are now sending patients out of Ireland to be treated. If they treat the causes of why procedures are deferred in our hospitals they could be spending that money more productively and also creating something better in this area for patient benefit into the future.

Clinician 3

There is also a degree of scepticism about the clinicians who have engaged in the 'clinicians in management' initiative.

To some extent I think some of the clinicians feel they (clinicians in management) have alienated themselves from the rest of clinicians. They have gone more management than they are clinicians, you know in feedback and approach. I think by having them there management is able to rubber stamp decisions – often about cuts. If you have got a deficit of five million or six million, and even though the clinicians are there, what can we do about that? It hasn't made any great difference overall. The crux of the whole thing is the funding.

Clinician 3

Management also recognise the difficulties and waste involved in not maximising activity given the high committed (pay) cost element of total costs.

I feel we are constantly being asked to square the circle. It's very difficult as a manager, knowing that the majority of the hospital cost is staff, to say cut back on activity when there are patients waiting to be seen and treated. The reality of trying to cap activity is almost impossible and unjustifiable when we have long waiting lists.

Assistant CEO – area health board.

The nature of health board membership also influenced the management process. Politicians are interested in "good news" to the detriment of development of appropriate systems to manage expanding health care allocations.

You see you get no marks as the CEO for involving the clinicians in management, or in doing clinical budgets or that kind of thing. There are no points in that. All I am saying is everybody is interested in developing services, opening new this, opening that, opening a door, opening a toilet and all of that stuff that goes out into press releases. Its very political. And the Board love it. They used to love it, the local politicians loved it. And the other stuff is just left by the wayside, better resource management and the like.

Director of Finance

7.4 Discussion and Conclusion

The allocation of funding in the acute services programme of the health board is decided on the basis of historical data. The current information systems in Ashford are unable to link activity with cost; for example, the annual budget is not directly linked to the service plan, neither is the computerised payroll system linked to the manual system for

capturing information on staff (WTEs) on a monthly basis. Activity is measured and income and expenditure is measured but these reports are stand-alone and are not integrated. The annual budget determination process is a top down process, though there is a substantial local consultation on the development of a service plan. The DoH&C consider the service planning process and its outcome, the service plan itself, as key to extracting accountability from the acute hospital system. However, in this hospital the clinicians involved in delivering the service have scant regard for a process that they view as having only a minor connection with the clinical services that they are responsible for. Implementation of the service plan is not supported by feedback of a financial nature. However, the quality of activity information has improved greatly. This combined with control information on staff numbers is increasingly used to manage the hospital. Financial information is used by hospital management to call clinicians to account, but these meetings appear fruitless in a service that is demand led and where nobody wishes to make hard decisions about curtailment of much needed services.

There are a number of reasons for the inadequacy of the financial support systems. Financial expertise is minimal. In an organisation with a staff of 2792 WTEs⁵⁹ in 2004 and a budget for 2005 of €215.5⁶⁰ million there are two qualified accountants. This is evidence of the low priority afforded to financial management of acute hospitals budgets. Evidence has been provided throughout this case of the frustration by all staff - clinicians, finance, nursing, allied health professionals – with the archaic financial information systems. The failure to invest in and develop financial systems is due to a number of factors: the composition of health board membership and the presence of political representation; the years of financial stringency in the 1980's (discussed in chapter 6); the personnel systems within the health boards of promoting from within at the middle management grade; the poor emphasis on staff development which has failed to support the management development of staff; the restrictive personnel policies whereby staff with little aptitude for accounting and finance are promoted into the

⁵⁹ DoH&C (2005).

⁶⁰ Draft Service Plan 2005 (Northern Health Board, 2004b:193) (unpublished).

finance department; lack of political leadership at national level to address the problem; lack of commitment and failure by staff at the DoH&C to persuade the Minister for Health and Children of the need to invest in financial management information systems to manage health expenditure. All of these factors have contributed to the present archaic financial information systems that are the primary financial resource management tool of hospital and health board management.

The existing batch system for updating financial systems means that it is difficult to trace costs within the system. As the general ledger is only updated twice monthly it is difficult to control costs using this system as a management tool. There is scarce time and expertise in the finance department to facilitate detailed costing of activity. There is very little staff training and development of staff in either the hospital or health board finance department. Training budgets are not devolved to departments, yet there is evidence of staff being denied training because the department training budget is spent. This is despite never being told what the budget allocation is.

Whilst at Ashford there is an attempt to involve clinical managers in service planning, there is no involvement of cost centre budget holders or non finance personnel in the process of determining their annual operating budget. There is a sense of powerlessness towards financial information by those who receive and who do not receive this information. Staff who receive financial reports query its relevance to them, whilst those responsible for large clinical departments do not receive financial information, but yet are called to account by hospital management for budget overruns. This anomalous process leads to tensions between management and clinicians.

Honest feedback on lack of resources to facilitate developments was provided, in the third and final service planning meeting, to all departments by the hospital general manager. Although this was considered a difficult meeting with staff, its value in recognising the difficulties and keeping communication open makes it worthwhile for many staff who chose to involve themselves in the service planning process.

There are particular bed management difficulties in Irish public hospitals, originating from the development of public hospitals and the role of clinicians. There are difficulties because of the mix of public and private patients deriving from legislation and the facilitation of private practice in public hospitals by publicly employed consultant hospital doctors. Whilst the Health (Amendment) Act, 1991, stipulates that only twenty per cent of beds in public hospitals can be used for private patients, a clinical emergency can overrule this, and frequently does, given that in excess of 45% of the population (see chapter 6) have private health insurance and that 70% of Ashford's admissions are emergency admissions. A quick calculation shows that on average at any given time, 31.5% of all admissions would be accounted for by private patients.⁶¹ Even allowing for admissions to the local private hospital still leaves it difficult to adhere to the 20/80 private/public mix.

Clinicians in this hospital have engaged with management since 1997 as clinical facilitators. Non clinical staff noted in interviews that this had proved worthwhile and fruitful as operational issues were addressed and resolved at bi-weekly meetings. The historical non-disclosure of financial information and the current frustration with long waiting lists and increasing public dissatisfaction has persuaded some clinicians that there are benefits to knowing about the budget for their service. However, in the case of all clinicians interviewed in the course of this study, knowing the financial information is not sufficient. If they are to be held accountable, they would like to have control over the selection of finance staff on their teams to manage their service budget. Clinicians in this hospital, unlike in previous studies – see Maddock & Morgan (1998) – do not see performance management as a “direct attack” on their profession, or at least don't say so.

Elements of NPM have arrived in this hospital via various vehicles: the National Hospitals Accreditations Process, the accountability legislation (the HAA 1996) and the

⁶¹ This calculation assumes that those with / without private health insurance are equally healthy.

partnership process at hospital level resulting from the National Partnership Process. There has been a change in focus at the hospital. Measurement is an increasing part of the vocabulary at Ashford. Increased budgetary pressures, as economic growth rates are predicted to slow, have precipitated exertion of stringent bureaucratic control by the Department of Finance on the health sector. Slowly emerging NPM ideas have been quashed by the emphasis on strict and inflexible staff number (WTE) controls. Hospital and health board management are expected to achieve a reduction in staff numbers and “yet minimise any adverse impact on existing levels of service to the public” (Department of Health & Children, 2003c:9). However, for 2005 approved developments were accompanied by a relaxation of the WTE control to facilitate the implementation of agreed projects. There has been a willingness on the part of clinicians to engage in management. One of the greatest impediments to improved management control is appropriate financial information systems. The lack of such systems undermines attempts to implement NPM ideas in practice as Hood (1995b) considers that accounting is a “key element” of implementation. It also leads to distrust of management and ultimately to the problem that results from poor levels of organisational trust: cynicism towards change (Andersson & Bateman, 1997; Laschinger et al., 2000), as individuals who distrust the system are compelled to resist (Culbert & Mc Donough, 1986).

In this hospital the communication climate is clouded by talk of adherence to budgets without the supply and distribution of meaningful financial information to clinicians, who are increasingly called to account for budgets. There is an expectations gap between the needs of clinicians to have financial information relevant for their service which they can use to manage, and the ability of the current systems to provide that information. Other studies have shown that there is a need to design management control systems to ensure that relevant information is provided in a timely fashion to key decision makers (Abernethy & Stoelwinder, 1990). In this case study it is clear in talking to all staff that they have almost “given up” on expecting any more from the hospital’s financial management information system. Reference was made to incidents

that may be perceived as procedural justice issues – failure to supply financial information, but yet a call to a meeting to determine what to do with a clinical service with large numbers of patients receiving treatment and others waiting to start treatment to stem advancement of terminal illnesses. Such use of financial information is pointless and creates tensions and resentment that dissipates throughout the hospital. Furthermore there is a degree of scepticism on the part of some clinicians concerning the involvement of those clinicians who have become involved in a ‘clinicians in management’ initiative. There is a danger that clinicians who are perceived as aligning too closely with hospital management, and who become too integrated into organisational administrative structures, may not then be able to assist in the resolution of the professional/bureaucratic conflict, as evidenced elsewhere by Abernethy and Stoelwinder (1990).

The quality and subsequent use of the financial information is critical to the successful implementation of attempts to increase accountability and control. Inappropriate use of poor quality financial information militates against successful implementation of NPM ideas. The core of the fragile hospital accounting system is the failure to invest in systems development over the years, by successive governments. This is due in large part to the political nature of health board composition in Ireland. It is also due to a failure by the DoH&C who, though they continually call on the hospitals and health boards for greater accountability, do not provide financial support to develop systems to discharge greater accountability. Discretionary spending for the scale of investment required to develop such systems was not available to either health board or hospital staff. Neither was financial skills expertise available at health board or hospital level for the scale of financial systems development necessary. Financial expertise in both the hospital and health board accounting functions was not supported by expertise at lower levels because of central bureaucratic establishment practices. The bureaucratic recruitment policies of both hospital and health board prevented the recruitment of staff with skills and aptitudes to support senior staff in the finance functions.

CHAPTER 8

MARIA THERESA HOSPITAL CASE STUDY

8.1 Introduction

In this case study accounting and management practices in an Irish hospital, transferring from religious to public ownership during a time of major public sector changes, are examined. This is not only a story of transition from religious not-for-profit to public ownership, but also a story of attempted transition to NPM ideas, structures and practices. However, this later transition is not complete as there is an absence of part of the accountability framework and accounting and financial information to support NPM ideas, structures and practices as outlined.

There is evidence of the managerialism of NPM in this hospital as a public sector organisation, but only some minor evidence of the structural component, with a change in the management structure. The hospital management process is intended to be supported by both the budgetary process (in the form of service planning) and the financial control process, via the reporting of historical financial results in the IMR on a monthly basis. This hospital interfaces for the planning and control of services and resources with the area health board and also to a lesser extent with the DoH&C. The story of transition reveals tensions and contradictions that emanate from these interfaces. The chapter is organised as follows: conceptual perspective, historical context, and research design (section 8.2), the study setting (section 8.3), public sector transparency and constraints (section 8.4), post health board ownership (section 8.5), and discussion and conclusions (section 8.6).

8.2 Context: Conceptual, Historical, Research Design

Information on each of the following necessary for an understanding of this case has already been provided: conceptual perspective (chapters 2 and 3), historical and organisational context (chapter 6), and research design (chapter 5).

8.2.1 Conceptual Perspective: Values, Beliefs and Organisational Forms and the New Public Management

The hospital studied in this paper started off as an organisation owned and managed by a religious order. It transferred to public sector ownership in November 2001. One particular feature of the Irish health system is the role of religious organisations in providing acute hospital medical services, initially on their own and increasingly with the support of state funding. This reality requires an appreciation of not only introducing NPM reforms in large specialised public sector organisations, but the fact that many of these organisations had and continue to have a strong religious ethos. This has implications for the recognition and tolerance of NPM type reforms. Key literature on values, beliefs and organisational forms together with the NPM literature (discussed in chapters 2 and 3) will be used to examine and explain the introduction of NPM ideas into this hospital and the role of accounting in that process.

In his seminal study of accounting in churches Laughlin (1990) observed a fundamental distinction between beliefs in spiritual issues (the sacred) and systems used to support them (the secular). This draws on Durkheim's thesis that all religion has a fundamental distinction between the sacred and the profane (Durkheim, 1915). Accounting is seen as a support activity and is profane: it is insignificant and unimportant to the core of the church organisation (Laughlin, 1990). This is not to say that there will be no accounting within religious organisations, but the sacred/profane distinction is a means by which the relative importance attached to accounting is explored. As Booth (1993:58) expresses it: its conceptualisation as a divide also recognises that the "sacred" cannot be completely separated from the "secular". Therefore, the necessary interaction between the two, particularly in organisational terms through various support activities around the "sacred core", means that the friction between them will be a fundamental aspect of organizational life. In taking this stance, Booth (1993:59) endorses the sacred and secular divide but cautions against its use other than as an "ideal" which is unlikely to be found empirically.

A study of the Church of Scotland by Wolfe and Pickford (1980) supports Laughlin's analysis. Wolfe & Pickford's (1980) document the accountings within the Church of Scotland. This reveals arcane accounting practices, which narrow the impact of information to specific accounting mechanisms (general and specific trusts), which are located within specific Boards of the Church. This locus of accounting information removes it from the central activity of the church and renders it invisible to its core membership. These findings offer a partial explanation for Booth's (1993) observation that there has been little study of accounting as a situated practice in churches to understand its impact and uses. The nature of religious organisations is not uniform.⁶² There are differences between and within an array of geographical settings. The study of religious orders (as in this study) in the context of them 'doing good for society' by providing acute hospital medical services to local communities is a neglected area. The phenomenon of religious influences on daily life has been described by Simmel, in (Wolff, 1950), in terms of organisations shrouded in secrecy. The manifest world (in this case, a hospital owned and organised by an order of nuns) is dominated by the secret world of the order. In this case, non-members of the secret world may be excluded from the business of the religious order. This consciousness of 'being different' is fundamental to the religious order, and creates boundaries around its activities. This behaviour reaffirms the potential classification of accounting information as irrelevant, as marginal, as profane.

There was a withholding of information on the future of the hospital, and also a withholding of information on the financial difficulties facing the hospital prior to transfer to the area health board, by both the religious order and hospital board. By comparison, the international trend towards the reform of the public sector (NPM) charts a contrasting course. As discussed (in chapter 3), this places measurement at the centre, with a strong focus on results and financial performance: all in the context of transparency (Pollitt & Bouckaert, 2000). The thinking characterised by Osborne and

⁶² There is a growing interest in studying accounting in religious organisations – see growing discussion in *Accounting, Auditing & Accountability Journal* (Duncan, Flesher, & Stocks, 1999; Lightbody, 2000; Davison, 2004; Jacobs & Walker, 2004).

Gaebler's (1993) evangelical stance on the need for public sector reform provides a sharp contrast to Booth's (1993) and Laughlin's (1990) observations on the nature of accounting in religious organisations. This tension is exemplified in this case study, by studying the practices of a hospital which has moved from a religious to a public sector organisation, at a time when the public sector is in the midst of radical reforms.

8.2.2 Historical context

To understand the nature of the change under discussion it is necessary to place the study setting in context. It is clear from Table I1 in Appendix I that the voluntary hospitals which have survived are those where there was a critical mass, who forged links and sought to come together to form stronger more cost-efficient hospitals in new facilities, which could accommodate advanced medical technologies (see Table I1 Appendix I). Those which are geographically isolated have transferred to health board ownership. The special characteristics of voluntary hospitals and their development in the Irish context were outlined in chapter 6.

8.2.3 Research Design

As noted in chapter 5, this study gathered evidence from a variety of sources: internal and external documents, some limited observation and interviews, including an interview with a religious sister who worked in the hospital in 1953 and who still holds a position there. See the following tables in Appendix A for a list of interviews relevant to the development of this case study: Table A2 – staff interviewed at Maria Theresa Hospital; Table A3 – staff interviewed at the area health board; and Table A7 – staff interviewed at the DoH&C. Interviews lasted between one and a half and two hours. Reports and sample accounting documentation were collected and analysed. Interviews commenced in April 2002 soon after transfer of ownership in November 2001 and finished in December 2004. This provides for a longitudinal focus to the study. It also facilitates an examination of the position after transfer of ownership to the health board.

8.3 The Study Setting: Maria Theresa Hospital

The Maria Theresa (MT) hospital was founded in 1943 and was owned and run as a voluntary hospital by an order of nuns until November 2001. A senior member of the order noted:

A number of Irish women entered our order in England and the order decided that it would be more beneficial to the advancement of our apostolate to have a foundation in Ireland.
Senior member – religious order

Like many public voluntary hospitals in Ireland in the eighteenth and nineteenth centuries MT was founded by private charity in 1943, but increasingly was aided by public funds.

They opened eleven beds. Their pioneering spirit was like any pioneering spirit. Sisters would get up out of their beds and sleep out in a caravan or sleep on a mat to provide beds for patients.
Senior member – religious order

Today MT has evolved into a 203-bedded hospital providing a wide range of services to patients. In September 1998, the religious order entered into discussions with the area health board regarding the transfer of ownership as it was concerned that as a result of its falling community numbers it would no longer be able to run the hospital.

It was a reduction in numbers and lack of sisters who were trained in the area of administration. Our order works abroad, you see, and a lot of people who wanted to devote their lives to religious efforts were keen to go to the third world, to places where 'the Message still hadn't been heard'. We did examine two ways of going forward: (1) to put the hospital in the hands of the trustees. However we didn't think it would be viable to have it completely private because there wasn't enough people who were able to afford that kind of treatment. So then we thought the best thing was (2) to try and make contact with the local authorities through the health board.
Senior member – religious order

In October 2001 the Minister for Health & Children announced that he had agreed to provide funding to allow the area health board to purchase MT hospital. Ownership of the hospital transferred to the area health board in November 2001. The budget for the hospital in 2002 was €32 million. €21 million of this was under the control of the Care Directorate. 75% of the hospital budget is pay, 25% non-pay. Activity at the hospital is increasing as measured under a number of different headings (see Table 8.1).

Table 8.1: Information on Hospital Activity

Year	Average in-patient beds available	% Occupancy	Average length of stay in days	Casualty attendances	Day cases
1997*	185	80.5	5.6	16,615	2,693
2000**	189	73.1	5.1	17,869	3,370
2002***	198	82.8	Not available	18,287	4,304

* DoH&C (2003b:Section H, Table H2A)

** DoH&C (2003b:Section H, Table H2D)

*** Information supplied by the hospital.

8.3.1 Past and Present Management Structure

Prior to this the hospital was managed by a Chief Executive Officer (CEO) and executive team. Over fourteen departments and independent professionals reported directly to the CEO. The executive team consisted of the functional heads of finance and personnel, doctors, nursing staff, staff from the paramedical functions, pastoral care and information, each speaking for the functional or departmental area they represented. There was little collective general management contribution from this team to the CEO who reported to a Hospital Board. This board was appointed by the religious order. The hospital board comprised eleven people: the local parish priest, two nuns, three clinicians (two local general practitioners and a hospital consultant) and five local businessmen – a solicitor, auditor, auctioneer, financier, and bank manager.

Prior to transfer to public ownership, hospital management were attempting to improve and develop management practices via the introduction of a new management structure. The current management structure (since January 2000) consists of three Directorates (Care, Medical/Cure and Resources). Each directorate is headed by a part-time Director. The senior administrative officer in the hospital is now called General Manager. The MT directorate model is based on the allocation to different directorates of people whose work is interrelated. The directorate model was introduced with the objective of giving key clinical professionals a greater say in the management, planning and development of

health services in order to bring about improvements in the quality of patient care. All hospital departments are aligned to a directorate as outlined in Appendix J. The Care Directorate is led by the Director of Nursing who is responsible for managing and representing nursing, catering and ward attendant staff. A consultant hospital doctor was elected by his colleagues as the first Medical Director and represents medical staff and staff in the professions allied to medicine such as pharmacy and physiotherapy. The Finance Manager is the current Director of Resources, representing staff in the finance, personnel, clerical, IT and maintenance areas. There are eleven staff in the finance department, and the majority of staff are concerned with invoice processing and payroll.

The three Directors and the General Manager constitute the management team. There is also a Medical Board which is the representative body of the consultant doctors in the hospital. Membership of the Medical Board is confined to hospital consultants holding permanent full-time posts in the hospital. The Medical Board mediates between the consultant body and Administration in the hospital. All major departmental decisions which have a bearing on the general consultant body are submitted to the Medical Board for its information and ratification. The chairperson of this board is the Medical Director. There are functional teams within directorates and operational teams across the three Directorates, such as the Equipment Purchasing Group. Both the Directors of Care and of Resources report to the General Manager and the Medical Director is accountable to the Medical Board.

8.3.2 Invisibility of Accounting Information

The period 2000 and 2001, was a time of fiscal crisis for the hospital which was characterised by a relative invisibility of accounting information in the more secretive religious organisation.

There was a great lack of awareness of financial information and lack of awareness of our overspend situation among the other staff – staff on the ground. I didn't mind being open about our overspend. It was no secret. At least if people were aware of our overspend, they might be more inclined to cut back or to be more careful of what they

were spending. People were delighted with the discussion of the budgets, they didn't have that before.

Ex Finance Manager

The finance manager was charged with bringing the hospital's finances into line so that it would appear as a not too unattractive target for a takeover of ownership and management by the area health board.

Our management meetings were different ... [speaking about before the 'clinicians in management' initiative]. They were very defensive with people minding their own corners. So we'll say the personnel department was looking after its corner and maybe wasn't sharing information with the rest of the team, finance and nursing was the same.

Ex Finance Manager

This position changed with the introduction of the directorate model and the move to more transparent management. The new structure required a sharing of information that brought issues to the fore that under the old management structure may have been discussed quietly with the CEO.

There was great transparency at the management table at the weekly management meeting. I thought it worked very well.

Ex Finance Manager

Working relationships between management staff improved under the new directorate structure and there is significant teamwork and co-operation

We would prepare it [a submission for funding] as a directorate.....So say it was something that the Medical Director was doing, I would get a copy of it and I would have a look at it and we would talk about it and we would amend it – that is the way we do our business.

Director of Care

8.3.3 Clinician Involvement

Consultant hospital doctors are interested in being part of the management team at the hospital. Surprisingly, given the longstanding apathy or hostility by clinicians towards management and accounting (see for example Jones and Dewing, 1997) the consultant doctors in this hospital accept the need for applying the principles of business management to management of the hospital.

It is vital that we [consultant doctors] have a lot to do with management...Yes, it [the hospital] is a business. It's a caring business but it's a business. It needs business management. Anything that has to do with having to live within financial constraints is a business. Now that was an objectionable word when the nuns were here. They wouldn't look at it that way but I think it's very true, it's a business.

Clinician

A positive outcome of the involvement of hospital doctors in the management process has been better working relationships between administrative and clinical staff.

The power of the individual consultant I'd say has been dissipated a little bit, but also going against that is the fact that consultants are getting a hell of a lot more information. People have stopped fighting in the corridors, arguing over small issues.

Director of Resources

The shift from the secretive organisation of the past to the new style, transparent public sector organisation has been welcomed by doctors. Consultant hospital doctors consider that they now have more control as measured by greater representation and voice at the local hospital management table.

Having a Medical Director means that I'm integrated into management and it means that now I'm at the management table at every discussion about every dogfight.... You see consultants never had a say at management level before and that led to incredible frustration.

Clinician

The structure of departments in the hospital remains the same but how those departments are represented at the management table differs since the introduction of the directorate/'clinicians in management' structure. The 'clinicians in management' initiative has improved communication at management level and throughout the hospital. Since January 2002 the three directors meet informally with the general manager each Tuesday and discuss and decide on issues of importance for the coming week. On the fourth week of every month, there is a more formal meeting where in addition to the three directors, deputy directors and staff officers of each of the directorates attend. Representative staff from personnel, finance, and IT attend as does the chairperson of the partnership committee.

8.3.4 From Secrecy to Transparency

Under ownership of the religious order of nuns there was a great deal of secrecy.

It was the nuns and the hospital board that really did everything with the ... Health Board and we were kept totally in the dark about it.

Clinician

Whilst there were structures in place such as the executive team and Hospital Board there was lack of communication of information about the change in ownership to staff in the hospital.

There's a lot of disenchantment with the way the nuns handled things, you know, ...the hospital board were kind of dealt the music by the nuns who owned the place and I don't think they had a lot to do with it. The chairperson of the board did maybe but I don't think they were given a lot of information either. They were a front organisation really.

Clinician

The nuns are still involved in the hospital in both pastoral care (one nun employed) and in mission effectiveness (one nun who works voluntarily), as a senior nun explained:

I suppose the essence of our order is to serve people with love and compassion. Pastoral care is different from Mission Effectiveness. Pastoral care involves looking after the sick: patients and also staff with problems, emotional problems. Mission effectiveness involves dealing with staff – trying to inspire and empower staff with our ethos and spirit – to serve with love and compassion.

Until transfer of the hospital to public ownership the mission effectiveness function had a chair at the management table, but that is no longer the case. That work is now facilitated, and continued but on a voluntary basis by an elderly member of the religious order. Under religious ownership members of the religious order working in the hospital were paid an amount for their hospital work but it was unclear to them how much they received.

Now we had an unusual system – it came from being religious people if you like, that we just didn't know what we were paid because it didn't come to us. Whereas when I worked in Africa for ten years, I worked in a hospital and while I didn't get the money into my hand, I got a sheet every month stating what my salary was – so much went to the bank and so much for uniforms. That was very professional. But that wasn't done here.

Senior member – religious order

The increased transparency in management meetings extends beyond the senior management. Summaries of monthly management meetings are available to all staff. With the new structure, staff know who to speak to if they have an issue of concern that they would like raised at the monthly meetings. This clarity in the information flow was not available prior to the introduction of the new management structures; then decisions had been shrouded in secrecy. Management meetings are also more productive as each member of the management team has to prepare in advance for the meeting and select three key issues of importance for discussion.

Each directorate prepares a monitoring report of what goes on for the month... it means that you have to share information before you go into the meeting. If there is an

issue... you will talk with whoever the relevant person is prior to going into the meeting, so that meetings don't become disruptive and defensive.

Director of Care

8.3.5 Negative Effects of 'Clinicians in Management' Model

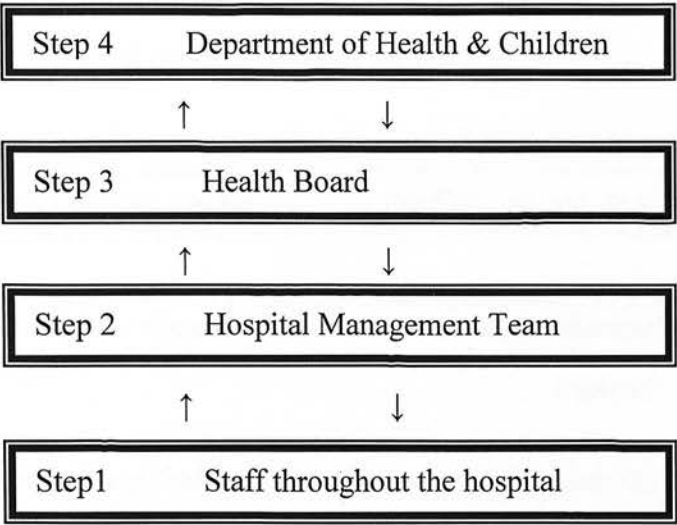
Involvement in the 'clinicians in management' initiative results in a loss of clinical time for consultant hospital doctors. This can have adverse effects on staff morale. When asked about the amount of time involvement in management consumes the Medical Director, though very much in favour of the involvement of 'clinicians in management', believes that the new management structure is under-resourced. He believes that adequate resources to replace his lost clinical time should be made available, otherwise it is unlikely that the model will continue to work in the future. The Deputy Medical Director also independently offered this view. This supports research on a review of the DoH&C's 'clinicians in management' initiative which identifies "lack of resources for both business as usual and for clinicians in management" as an impediment to progress of the initiative (Office for Health Management, 2002).

8.4 Public Sector Transparency & Constraints

There has been an increase in the influence of health boards in the planning and control function of hospitals since the introduction of the HAA 1996, 'the accountability legislation'. The effect of this Act has forced planning to take place in hospitals, via the service planning process, and has resulted in attempts at increased control of hospitals by health boards. Under the HAA 1996 each health board is required to prepare, adopt and submit to the Minister of Health & Children a Service Plan within 42 days of receipt of the 'Letter of Determination / Allocation'. The service plan details the planned activity that will be delivered for the funding they have received. This is a bottom-up process which for the acute hospitals division of the health boards starts in the hospitals. Hood (1991) argues that NPM has had a greater impact on front line delivery units and less on controlling departments. There is evidence to support this statement in this case. Whilst the accountability legislation requires the health boards to prepare service plans within forty-two days of the receipt of the 'Letter of Determination', the greatest change

in the planning process occurs at hospital level where staff are now forced to plan and are required to consider the link between activity and budget. The management control framework is set out in Figure 8.1, as a top-down process. Figure 8.1 also sets out the steps involved in the service planning process numbered as step 1 to 4 below, starting at the departmental level in the hospital.

Figure 8.1: Channel of Management Control and Service Planning Process Path



The budgeting process in the hospital is the service planning process. This process starts mid-year and requires substantial time and involvement from staff throughout the hospital. However, this transparency is accompanied by public sector rigidity: a major tension. The annual budget for the hospital is not known until December each year. The budgeting process is on a year-by-year basis, which results in problems of planning for services over the medium to longer term.

You see there is no proper budget strategy as such. There is no over arching plan and that is not the health board's fault, part of that is the way the Department of Health works.

Clinician

The service planning process, which started four years ago, requires the involvement of staff (step 1) throughout the hospital. Initially there was a very positive reaction from staff when asked to become involved. However, the guidelines issued to staff to prepare departmental plans did not specify the detail or length of the plan. The result was that a great deal of effort was expended by staff, who were subsequently disillusioned with the final plan as it related very much to maintaining the status-quo of the hospital. Only a fraction of the budget related to development monies to expand and improve services.

Overall understanding of the purpose of the service planning process has improved over time. The guidelines issued to the hospital for preparing the plan are clearer and this has contributed to an improved understanding of the process.

I think the service planning process is much more directed, more focused and that is what it needed to be. Before there used to be an A, B, C idea where something you really wanted, something you wished for and something that was out of the world and you were never going to get. I think that is falling out a bit now so it's more realistic.

There is very good follow up on the plan on an ongoing basis. In a way the plan is shelved but I think the follow up is tighter and I think people understand it much better. It's about getting it into the initial plan – that is the big problem.

Clinician

The Medical Director identified benefits other than service planning for the short term in the information coming back to the management team, via the service planning process, from staff throughout the hospital – identification of priorities by staff in departments and identification of areas that might form the basis of shared projects with other hospitals in the region. The transition to the ideas of the NPM on how public sector organisations should operate has not taken effect seamlessly. Local hospital management are charged with distilling the service plan inputs (step 2) from all departments into a manageable document for the health board. This input subsequently is further distilled at health board level (step 3) into a summarised version, which is then submitted to the DoH&C (step 4). The detailed feedback received from staff throughout the hospital does not reach the DoH&C. The subsequent further distillation of the hospital service plan at health board level on occasions 'creates noise in the

communication process' between the hospital, health board and DoH&C. The version that finally reaches the Department is something that the health board might wish for but local hospital clinical staff are unaware of. This produces a form of transparency in which means and ends can become opaque, dependent on perspective and focus:

Our last nine page service plan generated after some considerable effort by this laboratory was condensed in the area health board service plan into a single line which ran something to the effect that 'The laboratory in MT is continuing its co-operation with 'X' Hospital' (50 kilometres away). Now there is absolutely no co-operation between the two laboratories on any level. So the single sentence that got into the health board service plan was inaccurate. ... It's a bit like butting your head against a brick wall.
Clinician

The control function of the health board has also increased with the HAA 1996: "the CEO shall implement the service plan on behalf of the Board so that net expenditure does not exceed the determination" (section 9). A further provision of the new accountability legislation is that "surpluses and deficits will be credited or charged to the next year's income and expenditure account" (section 10). Since the hospital transferred to health board ownership in 2001, health board managers increasingly seek explanations of cost overruns on a monthly basis. The planning and control functions are part of the total function of management. Whilst it is clear the planning process is driven by the "new accountability legislation" it is more difficult to define who controls and where control exists in the hospital.

8.4.1 Accountability and Control: Tensions and Contradictions

As in many other hospitals, whilst a great deal of effort is expended on the planning process, there is "an absence of clear accountability for relating clinical and other budgets to outputs" (Department of Health & Children, 2003d:18). After monies have been expended there is little evaluation of results against budget. Demands for accountability by the DoH&C are frustrated in part by the failure of the Department and health board to sponsor the development of management information systems to support local hospital management decision-making, evaluation and control.

While MT hospital has moved from an accounting famine in its religious period of ownership to one of an abundance of transparency in the public sector, there is the caveat that much of this abundance is irrelevant information. It is not possible for individual hospital managers to make the connection between budgets and activity as the design of the hospital's information system does not facilitate this. Clinical staff do not know their budgets and are therefore unable to begin to control expenditure using budgeting tools. This hospital's accounting system (like many others) has developed around the requirements of the DoH&C and provides little useful information for managing expenditure. The IMR is the main means by which health boards report on their financial performance to the DoH&C. The resources of the hospital's finance function are centred around producing historical financial information to submit to the area health board to facilitate their preparation of the IMR for the Board for submission to the DoH&C.

In the past, and this includes the very recent past, information on budgets was not distributed to staff but was controlled tightly at the centre by the finance manager and management team. Seventy five per cent of the hospital budget is a pay budget. In 2002 the director of nursing was responsible for controlling costs for 450 of the 600 staff in the hospital. The directorate structure with its inter-functional focus has made visible the lack of financial information available to directorate managers to manage their areas. This has resulted in increased demands by managers for more financial information. It is now clear how difficult it is for managers to manage in a vacuum of financial and management information. Public sector ownership has made visible the dearth of information flowing to senior managers.

I was twelve months here before I knew what the actual budget was for my area.
Director of Nursing (joined November 2000)

The accounting information which is received by staff on a monthly basis and which is intended for information and control purposes is not useful for facilitating management control of costs.

We receive very little accounting information from the accounts department. There are many lines of information which are totally irrelevant. We receive a report with one line for the cost of all nursing staff. It needs to be broken down into ward sisters (now called clinical nurse managers), staff nurses, staff midwives, care attendants rather than just pay. I haven't seen any reports that can do that.

Staff Officer

The primary aim of empowering managers to manage under the new directorate model is frustrated by the lack of management information to inform decision-making. When the finance manager was asked "When were these managers last asked what information they would like to manage? He replied "I don't ever recall them being asked what information they require to manage". As a result some department managers find that the information they receive is limited in terms of its usefulness and understandability.

The information that feeds through to us here [in the Care Directorate] is what is submitted to the Department of Health but then you are submitting it to financial gurus there.

Staff Officer

There are also some clinicians who are interested in receiving financial information but the current system provides very little information of relevance to decision making in clinical disciplines. There are challenges for accountants to devise accounting systems in hospitals which connect with medical thinking (Jones & Dewing, 1997; Lapsley, 1997). Nevertheless, on the part of these doctors, there is a willingness to control costs.

You have to know what it costs ...the injections that we use and the tablets and the therapies we use...but we don't know what they cost.

Clinician

In the absence of management control information from the accounting function some staff have developed their own management accounting information systems to (i) provide information for planning and development of departmental services, and (ii) to facilitate cost control.

I set up this financial information system because as a scientist here in the lab I want to know about this kind of information. We accept that accounting is important. I lobby the hospital constantly for funds. I'm like a lobbyist now rather than a scientist in this position as administrator in the laboratory.

Senior Technologist.

It's [the monthly accounting information] not presented in my view in a very user friendly way, it's probably very user friendly if you are an accountant! We generate our own accounting information since I've come here. We have broken it into departmental cost centres and then items common to the whole lab, quality control, education, journals... so I have some kind of grip on costs.

Clinician

The answer then to “who controls” is that it is not hospital management. There is insufficient information to allow them to manage. There is little discretionary allocation of resources at hospital level. Practically all funding is allocated by the DoH&C to the health board and then to the hospital under specific headings.

...that [the allocation of resources] is really all done at area health board level and our management team do their best to allocate what little is available locally. It's on a sort of peanuts level.
Clinician

The above weaknesses of the MT hospital's accounting information reveal the frailties of accounting within public sector hospitals: a shift from the invisibility of accounting in the religious context to the visibility (transparency), abundance and the disconnection of the public sector.

We should receive accounting information but we don't. We did at one stage, we tried to get it up and running, that every month they'd tell us how much we were spending, because we officially have a budget, I think.
Senior Technologist

One of the ways in which the area health board attempts to control spending and to try and come in on budget for the year is to hold a contingency fund at health board level. In 2002 the acute hospitals in the area health board were allocated their budgets in the 'Letter of Determination'. A number of weeks later the hospitals were advised that the monies allocated had been reduced as the health board was going to take a percentage from all budgets and hold it as a contingency fund. As noted by the general manager: "It's like taking sweets off a child once they have been given". Such action is fuelled by legislation (the HAA 1996: section 10) which threatens to carry forward spending deficits from one year to the next.

Whilst there is a strong focus on staying within budget there is little focus on the connection between budget allocated, services delivered, and expenditure incurred. The issue of accountability is perceived in many ways by staff throughout the hospital. The focus of the responses from meetings with staff was primarily on managerial accountability and accountability to the DoH&C for monies allocated to the hospital rather than services provided by the hospital to the citizen or patient. This focus at hospital level is driven in part by the intent focus at health board and DoH&C level to

ensure that hospitals stay within budget limits. For staff who actively seek out efficiencies and undertake value for money initiatives there is little reward.

There is nothing within the system that acts as an incentive for efficient users, nor is there any disincentive for those who are inefficient and that's the way it is.

Senior Technologist

As channels of communication were historically narrow and limited at the hospital, staff have used their involvement in the service planning process as an outlet to air their aspirations and this has resulted in much noise in the service planning information fed back to management. The focus is on plans for the future if development monies are received rather than on the most efficient use of existing resources. The service plan is but one of the NPM tools used by Government to attempt to improve public service management and accountability in the Irish health sector. However, while it may be useful in justifying budget allocations, there is little follow up on the link between resources received/consumed and services delivered.

Nobody was held accountable. They [the DoH&C] throw out money, but they never follow up as to how it was spent. The level of accountability is minimal. For example, we could get two hundred thousand for a consultant geriatrician and support staff, I never saw them once come down and say "well show me where you spent this".... Never once have I ever seen them to follow up. ... At the end of the year we are overspent, but why are we overspent? What are we overspent on? What services caused the overrun? There are none of these questions.

Ex Finance Manager

Therefore at hospital level there are a number of impediments that management face in carrying out their task of management, including insufficient financial and management information to inform decision-making and insufficient discretion over the use of resources to reward staff engaging with the efficiency and accountability demands. In addition historical resource management has also contributed to the current resource position.

8.4.2 Tensions created by Historical Resource Constraints

Over the years there was recognition by the religious order of the need both to control financial resources and to raise additional finances to augment those received from the DoH&C. As a senior nun explained:

Sr. MP [a member of the religious order] was a fantastic person with finances and put a lot of curbs on departments and I suppose made herself a bit unpopular. But we were trying I suppose to run the hospital at the cheapest, well not the cheapest, no – the most efficient to provide the services that were necessary.

During ownership under the nuns there were many local initiatives to raise finance for equipment and new technology.

There were a lot of local efforts to finance the hospital. For example, the cat scan – we decided we needed a cat scan so we set up a cat scan committee. I happened to be secretary on that and went round to all the various localities here collecting money, and we got the money for the cat scan. Every year, for example, during the annual festival week we (the student nurses and ourselves too) would go down into the pubs and hotels to collect money.

Member of religious order

The shift to public sector ownership and new style public sector management has not resolved issues of lack of resources and the capacity to provide management information. This may be partly explained by historical reasons.

Part of the reason there's a problem here with under-funding, is that the nuns actually ran this place on a fairly tight financial basis, that's the way they run things, so I think the hospital has been chronically under-funded for a long time. Clinician

This view is supported by a senior member of the religious order: "Yes, we did run the hospital as economically as possible". As the national hospital budget allocation mechanism is primarily on an historical basis plus an allowance for inflation, current resource constraints are in large part a result of past tight budget management. Financial constraints have always been the greatest challenge facing staff at the hospital, both before and after the transition to public sector control.

The religious ownership pared down things. We used to have pencils tied to desks at one stage. We come from that kind of environment, which was very negative in some ways in that you didn't move forward quickly enough.

Senior Technologist

Directors of all three directorates were unanimous in their agreement (unprompted) that the greatest challenge facing them in carrying out the job was the lack of financial resources.

The budget, the lack of finance, that is the biggest challenge that I actually have. Not enough money to deliver the service that we are required to deliver.

Director of Care

The existing capital infrastructure position is a result of past investment.

All of the competition has been upgraded apart from us. ... We have had zip in regards to upgrading for years and it's a gripe I have with the nuns as to how the place is static, but you never stay static, you're running downhill. So we were running downhill for years and there was no growth and development in the area and now we suddenly realise when you look around, the place is a dump. Clinician

In advance of transfer of ownership to the area health board, staff appointments in certain areas were made to bring practices in the hospital into line with practices and supports in the other acute hospitals in the area health board (see Table 8.2 below).

Table 8.2: Personnel Statistics Acute Hospitals in the Area Health Board

	Maria Theresa Hospital Staff *		Large Acute Hospital in Area Health Board Staff**		Area Health Board, Acute Hospital Staff ***	
	Total staff	Management as a % of total staff	Total staff	Management as a % of total staff	Total staff	Management as a % of total staff
December 2000	473	69 <i>14.6%</i>	1753	237 <i>13.5%</i>	3795	475 <i>12.5%</i>
June 2003	666	99 <i>14.8%</i>	2030	341 <i>16.8%</i>	4533	696 <i>15.4%</i>
Growth in staff numbers	41%		15.8%		19%	

Source: * DoH&C (2001d:1)
 ** DoH&C (2004c:20-23)
 *** DoH&C (2001c:5-8)

Table 8.2 shows growth in staff numbers at MT in preparation for transfer of ownership to health board ownership. It confirms what a senior health board manager said, i.e. that "Maria Theresa got sorted out staff wise prior to transfer to health board ownership". Management staff as a percentage of total staff remained almost constant in MT compared to the other acute hospitals in the Board, where management staff as a percentage of total staff increased. Overall MT benefited from significant increases in

staff numbers (41%) from December 2000 to June 2003 relative to the other acute hospitals (19%) in the health board.

However, there is evidence that this hospital has a smaller non-pay budget relative to total budget as compared with other acute hospitals in the area health board (see Table 8.3).

Table 8.3: Non-Pay Expenditure at Maria Theresa relative to other Acute Hospitals in the Area Health Board

	Maria Theresa Hospital	All acute hospitals in area health board	Largest acute hospital of four in the area health board
	%	%	%
Pay expenditure as % of total expenditure	75.9	70.8	67.2
Non Pay expenditure as % of total expenditure	24.1	29.2	32.8
Total	100	100	100

Source: Area Health Board (2004a)
(Data for year ended 31st December 2003)

This table substantiates clinicians claims at MT that they do not have and never did have money for biros, bedpan washers, extra drip stands etc. that they have in other hospitals as described by two clinicians in interviews. The non-pay expenditure lags behind that of other acute hospitals in the area health board.

8.4.3 Current Resource Constraints

The DoH&C implemented a crude form of budgetary control, control of staff numbers in the form of the WTE capping, from January 1st 2003. Recruitment of staff beyond the ceiling in place at 31st December 2002 requires DoH&C approval. In the two year period between December 2002 and November 2004, only 24 additional staff who were attached to a service taken over by the health board, and a small number of additional other WTEs, were approved in the entire health board area, including mental health, community health and acute hospital services.

At the moment one of the greatest difficulties would be the whole time equivalent (WTE) ceiling. The bar we have on employing more staff is probably the biggest challenge closely followed by the budgetary pressures.

This is a person intensive industry, I mean 70% of our budget roughly speaking goes on pay, so if you are given money to develop a service, but the only way you can take on extra staff is by suppressing a post somewhere else, it makes it very, very difficult, because I would contend that at our stage of development in the Health Services it isn't easy to identify a place where you can say, yes that is overstaffed we will knock it there. It's not like private industry where you can say well this division isn't actually making a profit, so we will shut it down.

Senior Health Board Manager

Since the introduction of the 'accountability legislation' in 1996, there is an increased focus on the financial position of each health board at the end of the year. Health board management are required by the legislation to deliver services within the constraint of the budget allocated to it at the beginning of the year. In order to facilitate this, contingency monies are held at health board level in the event of a financial overrun in any area of the Board's activities. This practice of holding a contingency is not confined to the health board. The DoH&C also hold contingency monies in the event of serious financial overruns at year end. This money, together with unspent monies allocated to health services, is released in December to health boards to spend by December 31st.

This practice leads to a hasty spending of money on minor capital projects, as a pre condition in accepting this late allocation is that it is once off. The alternative is to carry the money forward to the following year as a credit balance, in just the same way as a

negative balance is carried forward as first charge on the following years budget. However, this more prudent carry forward practice carries with it political risks, as the public have been outraged by newspaper reporting of large credit balances carried forward in this area health board at the end of 2003, at a time when there were/are long waiting lists for hospital services.

What can happen is that a lot of money comes down (from the DoH&C) in December. Now, you are asking in September, is there anything coming lads, is there anything coming? In October you ask again. And you know they say no, no, no and then in December it comes.

Now we are always aiming for a break even, so you have contingency, you have to have, because if we get the 'winter vomiting bug, now in December, we have got to be able to deal with it. But if you get five million, or eight million or ten million or in one year it was seventeen million, down in December and you have been shooting for a breakeven as near as makes no difference, you are going to come in, in credit, or you really are going to spend money very foolishly. Senior Health Board Manager

Whilst this practice may strike some as encouraging inefficient spending of money, in this hospital staff have become accustomed to this practice and are ready with their lists of minor capital projects. Tenders and estimates in line with required public procurement requirements will have been completed. When money does not flow through at year end this will have been a waste of time and resources.

So you have got to be teed up and then you have people you can tick off the list. It's a great kind of morale booster, it helps deal with risk issues. Example: If you are trying to get into a situation where you are doing much less lifting, now you can buy some hoists and that kind of thing. You are ticking a lot of boxes. You want to do it sensibly, so it is about being ready.

But sometimes if you knew that money was coming ...it might be that what you really wanted to do was x but it's not feasible to do it in three weeks, especially when two of those weeks are Christmas and New Year. You might have an area of a ward that you really needed to refurbish but in fact the only time you can probably do it is August, September, when people are on leave and things are quiet. So sometimes it just goes to second best priorities. Senior Health Board Manager

This reference to being ready was supported by several other staff during interviews.

There is also a perception of less discretionary resources, post health board ownership.

The nuns were always very tight and they were always looking at the last halfpenny, we never had spare bread rolls, you never had spare anything. So it was always very tight. ... But I would say it has got tighter. We have had to be so careful about every halfpenny we are spending and there isn't any flesh.

When I visit other hospitals, which I have to from time to time for various reasons, I see lots of stuff they have that we don't have everything from dressing gowns which we don't have to better furniture in the wards, a ward that has more recently been cleaned and refurbished, to more drip stands.

Clinician

8.5 Post Health Board Ownership – A Happy Marriage?

There have been difficulties with the transition to health board ownership in November 2001. The primary difficulties centre around funding and development issues at the hospital.

I think it must be the most negative part of the history of the hospital, the three years that it spent with the health board.

Clinician

This was not an individual view as a senior health board manager agreed that:

It is very clear that within Maria Theresa there are many people who don't feel integrated.

Senior Health Board Manager

Part of the reason for the negative experience post transition was caused by 'falling between two stools' in receiving funding for capital developments. Applications to the National Development Fund took place in the period prior to transition, during the hospital transfer negotiation phase. MT did not make its own application to the Fund, believing that the area health board was including them in their application. This was the case. However no development monies were forthcoming. The result was a loss of capital monies for growth and development. The consequence is a perception and fear of downgrading of the hospital and a relegation to non-acute hospital status.⁶³

We never got any National Development Plan (NDP) funds. The Western Health Board say that the Department of Health did not give us any, and the Department of Health say well we gave you [the health board] funds for Maria Theresa. But the funds were already spent the previous year. They had been used to shore up a big thing outside A&E in Ashford [a new canopied entrance at Ashford]. We never got a red cent. Now that had a major impact on us because a lot of other areas got growth and development monies. We weren't allowed the privilege of growth and development.

Clinician

The health board explanation for this is that the development monies were not forthcoming as the downturn in the economy coincided with the integration and the

⁶³ The recommendations from the Hanly Report (Department of Health & Children, 2003e) have been adopted for both health boards examined by the Hanly Group. These have seen two of the smallest acute hospitals in the rural health board area singled out for downgrading (see chapter 6).

promised monies never materialised. The hospital has a history of involvement by the local community in both management and fundraising (see section 8.4.2 above). Once the lack of development monies became apparent, a Local Hospital Action Committee was formed to lobby for funds. This group applied pressure on local politicians for a meeting with the Minister for Health & Children to seek additional funds. This action was successful.

We had plans of things that we needed to do. They never happened. So help came, not through the health board, but through meeting the Minister, which we did. It then became apparent to other powers that we needed help. Money came directly from the Department of Health and Children. So the Department of Health and Children I think realised that we had been in an invidious position and fell in behind us. That didn't improve relationships with the health board.

Clinician

8.5.1 Increased bureaucracy – slowing the pace of development

Health board adherence to the WTE numbers control resulted in delays in opening capital developments at the hospital which had been completed. Adherence to the WTE ceiling meant that new staff could not be recruited to staff a new unit unless they were transferred from elsewhere or recruited to replace staff who had left other areas of the hospital. This was a frustration for staff at the hospital faced with a demand for a service and an unopened newly equipped unit on site.

One of the major issues we had was trying to get our new theatre block open. If we were dependent on the health board that would still be closed. So we had to do something about that. Then most recently we had to get the hospital central supplies department upgraded. We simply had to get money for that. We had to get money to upgrade equipment in the hospital and other areas of that nature and they didn't come from the health board, they came directly from the Department of Health and Children through us lobbying.

Clinician

A further change over the three years since transfer to health board ownership is the increased reliance on the service plan as a tool to seek, allocate and control resources. Prior to transfer, this hospital could include locally agreed priorities for the hospital in its individual service plan to the DoH&C. Now that has changed. The health board decides on priorities for each hospital, and it is becoming more difficult to influence this process.

You see we send in a draft service plan [to the health board] which is cut downwards, so that a lot of what we put in doesn't ever get into the plan. But some stuff doesn't get through because it doesn't suit the health board to have that in there. So you are being restricted. ... Our autonomy went down the tubes.

Clinician

In addition, operational issues take longer to resolve and complete. For instance, in the area of approving flexible work arrangements, these have to be approved by the health board headquarters human resource management function, sixty kilometres distant. This results in delays.

We might make a decision here, but then HR [at the area health board headquarters] have to approve it. It takes longer for appointments, parental leave approval, job sharing arrangements, and anything like that. Assistant Director of Nursing

8.5.2 Unmet Expectations

The expectation of developing integrated services has not materialised in the three years post health board ownership. The hospital still operates very much on a stand alone basis. It has unused theatre capacity that could be used to accommodate minor procedures, for which there are waiting lists at the largest acute hospital in the area health board. One area that gave rise to particular tensions was the development of oncology services. The hospital was allocated one quarter of the budget they delineated in their service plan as necessary to run the service. This resulted in further tension with health board management over the future of the service.

One of the areas that had a major impact on us was the oncology service. We were keen to have it. The health board were keen for us to have it, but in its start up year we only got a quarter of the money needed to run it. So we said what happens after three months? I said [to the CEO of the health board], we'll run it January through April. Then they [the patients] can all go back to you in Ashford for the rest of the year. But the CEO said: "You can't do that, find the money, are you able to effectively manage your finances or not?" Clinician

This related back to a point made and perspective outlined in an interview with one of the clinicians in August 2002.

I do know in hospitals X, Y, and Z [the other health board acute hospitals] that when they make bids for new services, that it seems that they put in much higher bids than we used to do. We'd put in what we thought were honest bids. It seems that what you need to do is put in ten times what you really want and then expect to get beaten down on it. We would have put in a realistic bid to the Department of Health and Children in the past. But I am beginning to learn that the situation is different now. Clinician

The history of the hospital, together with this sense of unmet expectations, has also impacted on the level of integration of the hospital into the acute hospital network. Senior health board management consider that this hospital has not made the required

culture shift to health board ownership. This failure they attribute to the hospital's historical voluntary ownership structure.

I think, because it was a voluntary hospital ... they would have negotiated their budget allocations directly with the Department of Health and there was a culture that at the end of the year if you had a shortfall you were helped out.

Now within the Board we corporately have to break even. I think there would have been the sense that perhaps Maria Theresa hadn't made that culture shift and were still prepared to run up a deficit as such and be bailed out, albeit in this instance by the Board corporately as opposed to the Department of Health. There was / is a sense that they were not feeling the pain that would be felt perhaps in other parts of the Board.

I suppose you see other places making very difficult decisions and I am not even talking about within the acutes, because what happens is:

If hospitals in the North West overspend, (and I am sorry it's not just in the North West, this is national), it's the community services budget which bails it out. And what that in effect means is that people are perhaps not getting the home help hours they need, they are getting some but not as much as they would need. It could mean somebody waiting for a stair lift, waiting for a grab rail in a bathroom. Maybe it's not as visible as somebody on a trolley in A&E. But these are not easy decisions either.

Senior Health Board Manager

8.5.3 Crude Control Measures impact on VFM and Development

Value-for-money initiatives were undertaken at the hospital under ownership of the religious order. For example, in the area of capture of data for the Hospital In-Patient Enquiry System (HIPE) a nurse data coder, who was to spend mornings on the ward checking hospital discharge charts and afternoons coding data, was recruited to improve the quality of the HIPE data being returned to the DoH&C for casemix funding purposes.

Basically we had to prove that this would actually create value-for-money within the hospital. Our ultimate aim was to try and ensure that we were capturing all the activity and that those costs that the finance department produce marry with our measures of activity. We did prove it to be a value-for-money post because we knew that there was additional activity out there that we were trying to capture and couldn't without some type of clinical help.

Hospital Inpatient Enquiry System (HIPE) Coordinator

In the beginning value for money was a big thing and we employed staff based on it, and it seemed to work very well. Then value for money was gone. So we are not allowed to employ staff on a value for money basis anymore. We have the ceiling of WTEs and that put a kibosh on that.

Clinician

This crude form of budgetary control also impacts on hospital development. Whilst funding may be allocated to develop a service, it requires a relaxation in the WTE

control to be allowed to use that money to staff that service. Yet this is not allowed for by the DoH&C in the funding allocation. The existence of this practice is supported by a statement from a clinician in this hospital and from health board senior management.

Within the context of this here [the budget allocation for 2005, the letter of determination on the desk] we are told we can have a physician and an emergency medicine specialist, yet there is no WTE for those people. So you are saying, with the strict limitation on WTEs, we have been granted this post but how will we get around the WTE ceiling? They [the DoH&C] will say, you have got to stay within your WTEs. You can't break it I understand the importance of sticking to your WTE level because that is where most of the money is going to go obviously on pay related issues. It makes it very, very difficult.

Clinician

In order to manage the regional health services in the board's area, health board staff have engaged in budgetary games in response to the tight WTE control pressures exercised by the centre of Government, the DoH&C, and the Department of Finance. The health board budget is divided into pay and non-pay and this is how the monthly control report is divided and returned to the DoH&C. The WTE control relates to the pay element of the budget. As a result of it the health board have engaged in contracting out some services. Budget and payment for these services comes from the non-pay element of the budget.

So we have been doing things like contracting out where we can and again we have probably run into barriers there because it is a very unionised industry. Obviously the unions would prefer us to directly employ more staff than contract out. So, that's very difficult.

Senior Health Board Manager

This contracting out practice also leads to difficulties in the future, as pay awards based on the pay element of the health service budget do not take into account the pay element hidden in the non-pay budget. The result is additional pressures increasingly on the non-pay budget to meet such pay awards.

It's quite artificial. How do you keep a handle across the board on this? Our budget would be broadly divided into pay and non-pay and within pay if there are national increments, if there is superannuation, if there are pay awards, we would tend to be funded from the Department of Health to accommodate that. Now if within your non-pay you have got this kind of contracting element which really is pay, but you are not getting the pay awards and the benchmarking and the parallel benchmarking you are storing up a problem for the future. This has happened to us before.

Traditionally there are areas we would have contracted, like contract cleaning, some contract catering, some contract laundry, and we would continue to do that. In the past where you had those areas contracted and the minimum wage was brought in we were

given minimum wage adjustments for our own directly employed staff but we weren't given it for the contract staff who of course we had to pay, you know because of the contract. I think we are storing up a hit for the future.

Senior Health Board Manager

8.6 Discussion and Conclusion

This case study chapter has summarised the process of how management accounting information has (has not) informed the management of this hospital as it moved from being part of a religious order to being a part of the public sector. The invisibility of the accounting information in the religious sector was a reflection of the secrecy of this kind of organisation. The shift to the public sector has aroused interest in, and demands for, better accounting information. However, the abundance of information available in the public sector is of poor quality: it exhibits a low level of transparency (it is 'there', but it does not connect with all/any decision-makers' needs). This shift from accounting famine to abundance has not improved this hospital's efficiency. However, the participants in the management process have positive perceptions of their influence in the new order. This is despite the contradictions that (1) accounting information is not sufficiently precise to let them shape events, and (2) that most of the hospital's budget is committed. Even if the appropriate accounting information was available, there would be little that management could do to deploy it in achieving a more efficient use of resources as they have limited discretion over resource use.

The transition of this hospital, formerly owned by a religious order, has important implications for accounting information. It demonstrates the importance of context in understanding the manner in which accounting is situated in organisations. For example, there is recognition from staff throughout the hospital that the focus has always been on efficiency. The previous owners believed this to be the case without the need for financial information to support this belief. The current underdevelopment of the accounting system has left present staff and management in the difficult position that they believe the hospital is using resources efficiently but do not have adequate accounting information systems to support an analysis of this to be the case.

There has been a failure to invest in a national uniform hospital accounting system which would provide information to facilitate health policy making and also provide managerial information to allow local hospital management to manage and to easily discharge accountability for the efficient use of resources. Hospital management have shown a willingness to engage in the accountability and measurement debate with new structures. While the new structures have brought increased awareness of the overall financial position of the hospital, the lack of detailed financial information and the lack of discretionary funds both leave management in a relatively powerless position. This results in difficulties in planning for a development of services. There is now a more inclusive management team at the hospital together with an increased flow and sharing of non-financial information and limited financial information. With this comes increased awareness of management issues surrounding planning, control and accountability. However, control is exercised by the DoH&C through the WTE capping and centralised budget allocation down to specific line items. Accountability is discharged by adhering to the staffing ceiling and budget rather than measurement against metrics such as levels of quality and service. However, MT are required to report on a set of performance indicators that have been prepared by the DoH&C in conjunction with acute hospitals (see Appendix K).

There has been a replacement of a highly centralised management structure with a broader cohesive management team. There is a closer focus on results in line with NPM thinking. The focus is on adherence to budgets as the financial and management information systems do not support the link between hospital activity, budget allocation and monies spent. There is evidence of the managerial component of NPM – there is greater visibility of hands-on management in the form of directorate meetings, minutes of which are available to all hospital staff. There is greater use of private sector management techniques with the service planning template and the use of such a template as the management document for monthly management meetings (see Appendix L).

The accountability of this hospital in its new public sector setting is both more transparent and more complex. Kaboolian (1998) argues that discussions of accountability too often focus on the characteristics of the mechanisms and processes of accountability. She prefers to focus on to whom and for what people are held accountable. In this case the hospital management team are focused on discharging accountability, for operating within budget, to the area health board and ultimately to the DoH&C. They do this within a climate of financial constraints. For Hood accountability involves “more active control of public organisations by visible top managers wielding discretionary power” (Hood, 1995b:97). In this case the management team are more visible since the ‘clinicians in management’/directorship structure was initiated in January 2000 but the level of discretionary management power is minimal. The transition to the new public management ideal is not possible in this hospital as the ideal at the core of new public management is centred around handing organisations dramatic flexibilities in return for serious accountability for results (Osborne, 2000). Flexibilities are not granted by the DoH&C but neither is accountability required of hospital management other than to stay within budget and WTE ceiling. However, accountability is more than a process of showing how money is spent. It also requires a demonstration that money has been used efficiently, effectively and for the purposes for which it was allocated. This link is missing in the accountability chain between the DoH&C, the area health board and the hospital.

There are political and managerial dimensions of accountability as described by Ferlie et al. (1996) in MT. Political accountability is the responsibility of the CEO of the health board as it is about the “party with delegated authority being answerable to the people” (Ferlie et al., 1996:316). Delegated authority remains at CEO level in the area health board. The hospital does not routinely publish financial or managerial information other than for submission to the area health board. The function of the CEO of each health board, embedded in the HAA 1996 (section 9), is to “implement the service plan on behalf of the Board so that net expenditure does not exceed the determination and

indebtedness does not exceed the amount specified". Not exceeding the budget limit is increasingly the criterion of performance that is sought. The link between the monies spent and the level of service provided is absent at the control stage. Of course information is collected on the level of activity in the hospital and this is reported by a function other than finance to the DoH&C by the HIPE co-ordinator. However, the link is not established between the historical monies allocated, monies spent and service delivered. The primary control focus is on the cumulative over/under spend. Managerial accountability is "about making those with delegated authority accountable for carrying out agreed tasks according to agreed criteria of performance" (Ferlie et al., 1996:316). The agreed task in this case is the delivery of the service plan within the budget limits. Increasingly it is adherence to budget limit that is the focus of managerial attention, as the criterion for performance, at both hospital and area health board level.

The directorate structure has resulted in an inter-functional focus. This differs from the very rigid functional focus that existed prior to the change. The transition from private religious to public ownership has not brought with it any significant development of systems to support the new management structure. There has been an increase in the supply, distribution and sharing of non-accounting information and this has led to a feeling of management empowerment and greater cohesiveness at local hospital level. There has also been an increase in the distribution of accounting information to 'budget holders' throughout the hospital. However, the structure and content of the accounting reports are in a format required by the DoH&C and lack the kind of information required to manage. Whilst increased accounting information is welcomed, it is often not understood by staff receiving it and is also lacking in depth to facilitate active management as outlined in the case of the director of nursing earlier in this chapter. Others admit the futility in developing more detailed accounting information systems, as the development costs would be pointless since there is little management discretion at local hospital level with resources controlled by the area health board and DoH&C.

CHAPTER 9

NORHOP CASE STUDY

9.1 Introduction

This is a case study of a relatively small hospital (Norhop) – a county hospital – in one of two area health boards examined in this thesis. In 2002/2003, all hospitals in this health board were examined by a government commissioned task force on medical staffing in public sector acute hospitals - The Hanly Report (Department of Health & Children, 2003e).⁶⁴ The concerns of staff in the hospital are influenced by the recommendations of the report, which are discussed in greater detail (in section 9.2) below. The importance of an understanding of context has been advanced throughout this study. Implementation of reforms as outlined in The Hanly Report will result in a change to a less favourable status for the hospital and the staff working within it. Information on each of the following necessary for an understanding of this case has already been provided: conceptual perspective (chapters 2 and 3), context (chapters 4 and 6), and research design (chapter 5). Additional detailed contextual information on the proposed reforms affecting Norhop is provided below in section 9.2.

The case study outlined below details the attempts that have been made to implement NPM ideas into practice in this the smallest of the four case study hospitals. Information on the case study will be examined and discussed as follows: context (section 9.2), data collection (section 9.3), the study setting (section 9.4), and discussion and conclusions (section 9.5).

9.2 Context

Information necessary to understand the detail of the case has been provided in chapter 4 – the introduction of NPM ideas into the Irish public sector, and chapter 6 – the social, historical, religious, political and institutional influences on the development of the acute hospital sector in Ireland. This hospital differs from the other three case study hospitals in that The Hanly Report (see chapter 6) proposes a change in designation for Norhop.

⁶⁴ See section 6.8 for details on the Hanly Report.

It recommends that Norhop should function as a “local hospital” (Department of Health & Children, 2003e:73). This would change its status from that of an acute county hospital and would see the removal of its out of hours accident and emergency services and out of hours consultant cover. Existing consultant numbers in this hospital would need to be increased from nine to twenty-one to support the model of acute health service delivery of a consultant-provided service, as envisaged under the Hanly Report. The basic minimum consultant requirement for an acute hospital service is seven consultants in each of three specialities – medicine, surgery and anaesthesia (Department of Health & Children, 2003e). Existing and projected population statistics do not support the call for additional consultant appointments at this hospital.

However, as noted in chapter 6, discussion of reform of the Irish acute hospital sector is not new. The Fitzgerald Report 1968 (see chapter 6) recommended that a general acute hospital should have not less than 300 beds and service a population of at least 120,000 (Consultative Council on General Hospital Services, 1968:25). The report recommended in 1968 that “as this (Norhop) is a 116 bed hospitalstaffed by one physician and one surgeon and as Norhop is only 23 miles from Southop (see chapter 10), we could not contemplate its development as an independent hospital centre... . We recommend that the hospital should have its role changed to that of a community health centre” (Consultative Council on General Hospital Services, 1968:110). This recommendation, similar to many other recommendations in the Fitzgerald Report, was not adopted. The primary reason for this was lack of political will. From the date of publication of the report there had been widespread local opposition to The Fitzgerald Report regarding proposed hospital closures (see Dail Eireann Debates (1969)). A majority government was in power in Ireland during the period 1969-1973. As the date of the next general election approached they did not attempt to implement the reforms outlined in The Fitzgerald Report despite being in agreement with them (Dail Eireann Debates, 1973). This historical context is necessary to an understanding of the present situation facing this hospital.

The current government has accepted the Hanly Report which recommends the appointment of 2,000 extra hospital consultants and major reforms, including withdrawal of A&E and obstetric services and out of hours consultant cover from many local hospitals (Department of Health & Children, 2003e). The intention going forward is that clinical care in acute hospitals will be consultant-provided rather than consultant-led as it is at the moment.⁶⁵ At present the government has not implemented The Hanly Report proposals.

9.3 Data Collection

The study gathered evidence from a wide variety of sources: internal and external documents (see Table 9.1), and some limited observations and interviews.

Table 9.1: Internal and published documents acquired from DoH&C, area health board, and hospital

DoH&C – Information Management Unit: activity information all acute hospitals
Letter of allocation and determination of budget from the DoH&C to the CEO of the area health board for 2002
General manager’s monthly financial report – county of Nortville (including commentary)
Income and expenditure monthly analysis for Norhop
Service plan for individual departments: cardiac rehabilitation unit, catering, pathology, physiotherapy and radiology
Norhop Nursing Management Monthly whole time equivalent control report
Norhop whole time equivalent reconciliation nursing report 2002
Area health board operational plan for the county of Nortville 2003
Understanding service planning in the area health board – guideline document (published)
Service plan for area health board 2002, 2003, and 2004 (published)

⁶⁵An explanation of these concepts was provided in chapter 6 and a concise explanation is provided again here. A consultant-provided service is defined as “a service delivered by teams of consultants, where the consultants have a substantial and direct involvement in the diagnosis, delivery of care and overall management of patients” (Department of Health & Children, 2003e:22). This contrasts with a consultant-led service defined in the Health Strategy (2001) as “a service supervised by consultants who lead and advise teams of doctors in training and other staff in the delivery of care to their patients” (Department of Health & Children, 2001a:203)

Tables A4, A5 and A7 in Appendix A detail the hospital and health board staff interviewed in the course of writing this case study. Details on the hospital’s services, activity and management structure are provided below, followed by an examination of financial and service planning mechanisms (section 9.4.1), resource management (section 9.4.2), accounting information (section 9.4.3), value for money initiatives (section 9.4.4), and implications of efficiencies achieved as a result of implementation of NPM ideas (section 9.4.5). This is followed by a discussion and analysis of the issues examined in the case study (section 9.5).

9.4 The Study Setting – Norhop Hospital

The hospital Norhop is located in the county of Nortville. It is classified as an acute general public hospital. Its physical infrastructure is described as “creaking” by the general manager of health services in the county of Nortville. Norhop is part of a health board comprising three counties: Nortville, Soutville and Eastville. The area health board is located 23 kilometres away in the city close to the large acute hospital, Southop (see chapter 10) in the county of Soutville. The board is responsible for policy decisions and for monitoring their implementation by the board's staff. Staff of the board are led by the chief executive officer (CEO) who, in conjunction with the corporate team, is responsible for the day-to-day running of the organisation. Operational management of area health board services is assigned to general managers who are responsible for hospital and community-based services. Services are organised according to care groups including acute hospital services, mental health, the elderly, childhood services, disability, primary care and community care. Brief statistics on population are provided in Table 9.2.

Table 9.2: Population of two counties in the area health board

	Nortville	Soutville
1966	73,597	137,357
2002	103,277	175,304
Population growth	40%	27%

Source: Central Statistics Office (2003:16)

Table 9.2 shows that the population of both counties has increased substantially over the period since the time of publication of The Fitzgerald Report in 1968, this being the first significant report commissioned to examine the location and organisation of hospital services. There has been a relatively greater increase in the population of Nortville as compared to Soutville (the location of the Southop hospital – see chapter 10). There has been and continues to be a great deal of community support for the hospital. For example:

A lot of the major advances here (technology) – the funding for them has come from private sources, from the community and you put them in and then defy the health board to take them out. ...We have money presently to build a cat scan here privately but it is difficult to get the health board people to come out or to send an architect out to see where we are going to put it.

Clinician

Norhop General Hospital is one of three hospitals in the acute hospitals programme of the area health board.⁶⁶ It employs nine consultant hospital doctors and nineteen non-consultant hospital doctors (NCHDs). Clinicians at the hospital have been involved in a ‘clinician in management’ initiative at Norhop since 1999. The hospital provides a relatively narrow and stable set of services and clinics including: antenatal, anticoagulation, breast clinic, day surgery, diabetic, ECG, ENT, general radiology, gynaecology, minor procedures, orthopaedic, paediatric, physiotherapy, and varicose vein clinics.

Details of activity are provided in Table 9.3, which shows a pattern of increasing activity and a marginal increase in resources. The bed occupancy ratio far exceeds the recommended desirable ratio of 85% (The Health Boards Executive, 2003:11). The hospital had been sanctioned for a €16 million capital upgrade (which is the size of its annual operating budget) in late 2002. The design team had been appointed but then a national report on medical staffing was commissioned (Department of Health & Children, 2003e) and the development plan was put on hold.

⁶⁶ The other two hospitals are Southop (see chapter ten) and Easthop which is not part of this study.

Table 9.3: Norhop - Activity Measures

	No of in patient beds available	In patient admissions	Available bed days	% occupancy	Average length of stay (days)	Day beds available	Day cases	Casualty attendances
Norhop 1994 *	85	4,822	31,111	98.1	6.4	6	2,021	18,009
Norhop 1997 ^	86	4,555	31,588	93.5	6.5	6	2,064	19,126
Norhop 2000 ~	88	4,766	32,208	93.8	6.4	6	1,712	20,884

Source: * DoH&C (2000:147)
 ^ DoH&C (2000:151)
 ~ DoH&C (2003b:176)

The senior manager is called the hospital administrator. He and the director of nursing share the secretarial services of one staff person. The hospital administrator is joined by the director of nursing and two consultant hospital doctors on the Hospital Executive Committee (HEC) which was formed in early 1999 at the encouragement of the chief executive officer of the area health board. The agenda for weekly management meetings is prepared by the hospital administrator. The hospital executive committee is chaired by a consultant hospital doctor. Prior to this management group:

There was nothing. Nothing. You had a medical board and you had the hospital administrator and you had the director of nursing. Each of us liaised and talked with each other, but we didn't come together and look at all issues that might be pertinent to the overall hospital.

Director of Nursing

The hospital administrator (de facto general manager) reports to the assistant CEO for acute hospital services at the area health board. He also has a dotted line reporting relationship to the general manager for health services in the county. Management meetings with health board staff responsible for the acute hospital programme are held infrequently, approximately twice each year – one meeting is held early in the year to consider “monies available and targets” (Hospital Administrator).

There are also Nortville county “Care Group” monthly meetings, which the Hospital Administrator attends, and where:

We discuss various things as well as finance, so we get an overview of all the Care Groups in Nortville – we get an idea where they're all at and what their pressure points are and what ours are.

Hospital Administrator

As it is an acute hospital a large percentage of admissions are emergency varying between 80% to 94% at different times of the year, with the greatest number of emergency admissions in the winter period. According to the Hospital Administrator:

There's more immediate issues to be dealt with here [in an acute hospital] .. than in the likes of elderly care where you can plan a lot – here you can plan a bit, but a lot of it is 'management as you go'. There's only so much planning you can do. It's all crisis management. It's one crisis after another.

This point is also supported by one of the clinicians:

Our set-up is: for the winter we're continuously chopping and changing work because the hospital is overrun with medical patients, 90% of the work we're doing is emergencies of all sorts. Then when the summer comes we try to catch up on the elective surgical lists. So we're using the beds which become vacant in the summer time to try and get as much work done, to catch up again, so that as we head into the winter we have the waiting lists as short as possible. It screws up the possibility of cleverly managing it, but for us that's the only way we can keep track of the work that needs to be done.

Annual budgets are allocated to all acute hospitals on an incremental basis, based on an historical allocation plus an adjustment for inflation, and additional development monies (if any). Financial overruns in any one of the three acute hospitals in this area health board are funded by savings firstly in the acute hospitals programme, and secondly by savings (if any) in other programmes of the board. The financial shortfall at Norhop for the past four years has been in the region of €600,000 (approximately 4% of the Norhop annual budget). There is now a greater focus on service and financial planning than heretofore.

9.4.1 Financial and Service Planning Mechanisms

There has been a closer focus on results in this hospital since the enactment of the HAA 1996. The service planning process is the vehicle through which the DoH&C purports to match resources to planned activity levels and to manage hospital services:

The 1996 accountability legislation has had the biggest single effect with regard to accountability and governance in the health boards. It involved the introduction of service planning, management reporting and accountability. Of the accountability legislation the first charge has been the single biggest issue that has allowed budgetary management.

Assistant Secretary, DOH&C

The first charge refers to the offset of a current year deficit against the allocated budget for the following year, thus reducing the available budget. The objective of service planning is that resources are matched with planned hospital activity. The service planning process at Norhop is outlined in Table 9.4 below:

Table 9.4: Service Planning and Review Process

Month	Activity	Nursing	Consultant Hospital Doctors	Non-Nursing Departments
Nov	Service plans are prepared for each unit in the hospital and submitted to:	Director of Nursing	Hospital Administrator	Hospital Administrator
Nov	Review Meeting (half day)	Director of Nursing and Hospital Administrator		
Nov	Further Review Meeting	The Service plan is laid before the Hospital Executive Committee for ratification		
Nov	Service plan is submitted to the health board			
Dec	Budget details are received by the health board in Letter of Allocation/Determination and communicated to Hospital Administrator			
Every four months	Review meetings are held by the Hospital Administrator during the year to assess progress on implementation	15 units/wards	-----	with paramedical groups

When the service planning process is complete the twelve-page service plan is sent to the health board where it is incorporated into both the service plan for the acute hospital sector and also into the service plan for the county. One sizeable disadvantage of the service plan preparation process is that “we can’t cost the service plans, because activity and finance are not related” (Financial Controller and General Manager, Nortville County). This inability to link resources with intended levels of service undermines not only the planning of services but also the control and management of resources as the

link between activity in the hospital and service levels is not well understood. Yet there are increasing requirements to better manage hospital resources.

The HAA 1996 has resulted in greater pressure down the line to adhere to budget allocations. Budgets are allocated for the hospital in the national governmental budget allocation process each December and advised to hospitals, via the area health boards, within days. Responsibility for remaining within budget rests with the hospital administrator and the Hospital Executive Committee. As 70% of the budget is comprised of salaries (fixed pay costs) there is little discretion over the use of financial resources and over the annual operating budget. The hospital budget is allocated by the DoH&C, with labels attaching to development monies, noting the service for which it is to be drawn down. Budget information is held centrally at the hospital and there is little understanding of the source and composition of this:

I'm not told what my budget is. I'm not actually given a budget. Other than the fact that the budget for nursing comes out on the overall spreadsheet, it has one line for nursing.
Director of Nursing

Some clinicians do not see the service planning process as worthwhile: "...a waste of time...because we don't have any input into the budget. It is just a number crunching exercise" (Clinician). Service plan reviews are supposed to be held quarterly. When the hospital administrator was asked if service plan reviews were worthwhile, she was emphatic that the reviews did add value:

..... If we have three [service plan reviews] a year, we are doing ok.

We sit down and we go through the issues that have been raised by the various departments and we would look at finance, activity, then significant issues and the new developments they wanted to do for the year. We look at areas like quality or value for money initiatives or whatever issues that we had agreed for the departments and we see where they are at with these. And then if there's things that I can do or need to do or if they need to do certain things, we'll just discuss this and see where we can go.

We want to make sure with people, once they buy into it that we can keep them bought into it.I know this doesn't happen in the other hospitals in the region – that departments develop their own service plan. Now I think it works for us here but it took a lot of selling to get them to buy into it.

The service plan review process clearly is a hospital wide communication process to endeavour to deliver on the service plan that has been agreed. Where resource constraints are a limiting factor, the hospital administrator lobbies the health board for additional funds to meet service level targets. However, from the foregoing it is clear that clinicians responsible for treating the patients who create the service levels in a demand led acute hospital do not value this process nor see it as worthwhile.

Attempts to develop performance outcome measures have been slow, given the outdated financial systems and lack of technological support. However, there is an appreciation by some staff of the need to develop quality related outcome measures: For example:

We are not into outcomes, most of the performance measures are output related, the number of people through, procedures.⁶⁷ What we need to do is link that into outcomes and we need to link it further then into health gain and social gain. Example: if somebody has cataracts removed there is a huge social gain, somebody with a hip, that's both a health and a social gain, we need to measure that....

Without development of outcome measures like this the management of waiting lists becomes meaningless by virtue of the fact that somebody could be on a waiting list for an orthopaedic procedure for four or five years – you have got to quantify the outcome of having a procedure done. An 80 year old waiting for a hip can have a huge quality of life improvement and a huge quality increase in relation to health and social gain by getting that done rather than waiting. In the context of the management of waiting lists we have to find some mechanism for doing this, because if we don't we'll still be back into just churning out numbers.

General Manager – Nortville County

Part of the reason for the slow development of indicators has to do with contextual factors. There has not been an ingrained history of accountability.⁶⁸ Prior to the “accountability legislation”, there were few obligations on health boards or hospitals to remain within the budget allocation. As noted by the CEO of the area health board:

I think we don't have that culture in this country. We are just moving towards it whether it's at the individual level or the unit level or the organisation level or whatever you would like to call it.

Service plans have not always been developed from the bottom up. Initially the service planning process was a top down process. This has changed on a gradual basis as organisational learning took place (see Table 9.7).

⁶⁷ A complete list of performance indicators for the area health board for 2003 is provided in Appendix M. However, this or a similar list on performance indicators was omitted from the 2004 service plan.

⁶⁸ See reference to accountability scandals at national level, resulting in Tribunals of Enquiry, in chapter 4.

Table 9.7: Devolvement of Service Plan Preparation and Development of Staff Consultation and Involvement in the Service Planning Process, 1997-2003

Year	Service Plan prepared by
1997-1999	Assistant CEO of Health Board
2000	Director of Nursing and Hospital Administrator
2001-2002	Director of Nursing and Hospital Administrator with increasing consultation with staff in all areas.
2003	Staff in units, wards and services – with limited involvement from the Hospital Administrator or Director of Nursing. The Director of Nursing’s involvement was limited to writing a summary for plans in the nursing area. All non-nursing service plans and plans prepared by hospital consultants were submitted to the Hospital Administrator.

The service plan has provided a focus in this hospital for incremental change and improvements, as evidenced by the following quotes:

Often some of the issues not dealt with in (the Service Plan) 2003 would be carried forward to 2004, and if you look at it over a series of years, you will actually see that most things get covered eventually. By and large, give it a three or four year cycle, a lot of the things that were on the list in Year 1 have been completed by Year 3 or Year 4.

Director of Nursing

Every year in the service plan we try and improve things within the plan without a change in our financial resources.What we write down that we are going to do in the service plan, we do unless we have a good reason for not doing it.

Physiotherapist

The service planning process also creates other visibilities. It became clear in this hospital, as a result of collecting information to prepare the service plan, that there were groups of general practitioners (GPs) who were referring patients elsewhere for treatment rather than to this hospital. This resulted in the setting up of a GP Liaison Committee to discuss this issue and to inform local GPs about the hospital services that were available locally and to encourage them to support their local hospital. As noted by the general

manager of Nortville county a number of benefits have emerged from the service planning process:

Perhaps they were not aware that this menu of services were available here, because the hospital has developed quite a bit.

Service planning has also allowed us to better manage our accident and emergency caseload more effectively, in the sense that we have built mechanisms, activation mechanisms, into it where there are x number of patients on trolleys in the A&E, and it's a very small A&E department, then we can activate and open the day unit. It means that there is a mechanism there that we can now do this. So there are more positives certainly in the service planning process than negatives.

Service planning...I think it brings all the main parties in relation to the provision of a service together as one unit. It gives a focus and a cohesion to the management of a hospital so it's not one group shouting and another group responding "oh we can't do it". There is now a collective response as to how issues can be addressed.

The service plan guidelines stipulate a heading –‘finance’- in the review section of the service plan template. However, this is frequently ignored and not completed. In a selection of the service plans reviewed, there is frequently a blank space under finance.

Example: Extracts of Section 2.1 Finance from the following Norhop service plans:

No need to insert anything here. Cardiac Rehabilitation Group Service Plan, section 2.1.

The catering budget is outside my control, but I discuss purchasing requirements with the hospital administrator. Catering Department Service Plan, section 2.1.

There was nothing under this heading for pathology or physiotherapy, whilst the radiology department noted that no budget had been allocated. Knowledge and control of the budget and financial information is retained at the centre of this hospital by the hospital administrator. The present financial information system makes it difficult to divide non-pay costs between departments where individuals have responsibility for different elements of the overall hospital budget. However, it is possible with costing initiatives to divide pay costs between hospital departments, but given that this is a fixed cost, with no discretion to change it by the hospital administrator, it is not considered useful to do this.

Towards the end of the year, in late November/early December, monies sometimes become available for one-off spending. Staff in this hospital plan around this possibility,

and lobby the hospital administrator for resources during the third quarter of the financial year. Should monies become available, the hospital administrator has discretion over the allocation of such finances.

What usually happens is around December, they say "we've got a bit of extra money". You have to be ready for this, because if you are ready, you can get equipment or something else once-off, but only if you order it by the end of the week. We will have got the quotes already in anticipation, as it happened before that we missed out and others got the extra money. This year we had a list ready, so when Tom (the hospital administrator) rang down and said "how long would it take for you to get rid of your waiting list?", I was able to think quickly and say – six weeks. He said "Ok, you can keep the locum for an extra six weeks". But this only worked this year, because I had a locum on site who was due to finish towards the end of November.

Physiotherapist

Whilst the CEO of the health board is responsible for remaining within the financial allocation under the HAA 1996, commonly referred to in interviews as the 'accountability legislation', there is a sense of a lack of a wider accountability for resource management at hospital level. For instance the general manager of Nortville county noted:

We don't have units of accountability. ... We need all the key stakeholders involved in incurring costs working as a unit and we must make them more accountable and that is the major deficiency because basically without that, it's myself or the hospital manager or somebody else trying to impose discipline in relation to cost management on a system which hasn't taken on responsibility for performance management or accountability and that is the greatest problem going forward.

These comments apply to a hospital where clinicians have engaged with the hospital administrator in a hospital management initiative since 1999. Despite this engagement there is a sense of central control only (by health board managers and the hospital administrator) for management of financial resources at the hospital, which may not be fully justified given the evidence of efforts by clinicians to engage in management of hospital resources presented in the remaining sections of this case study.

9.4.2 Resource Management 'Clinicians in Management'

In 1999 the assistant CEO of the health board with responsibility for acute hospitals decided to set up new hospital management structures, and the Hospital Executive Committee was developed.

They (health board management) decided that the Executive would consist of the Director of Nursing, the Hospital Administrator, and a Consultant. It was initially to be one consultant but they (the hospital consultants) felt that was two management people and only one consultant. The hospital administrator and I were told – it's your function, so you go on it. From the consultant point of view the Medical Board decided on who their two reps were going to be from the outset. The consultants said they would go on the Executive provided they had the 'chair'. Now neither Tom nor I have been put in a situation that we've had to fight that one. In real working terms, it's more a name than anything else, because it is very much the four of us working together.

Sometimes, it can be a bit top heavy with medical subjects, or medical interest, because there are two medics on it. And quite often, I can be very vocal, and I can bring up the nursing issues, but I find that the clerical administrative issues that Tom might have, get very much put down to the bottom of the line. But we're actually very lucky, because we're small, there's not a huge amount of conflict between the four people. There is the odd spat, but you're not going into a confrontation situation every Friday morning.

Director of Nursing

There is some concern around the issue of trust expressed by both clinicians about the objectives of health board management in involving them in hospital management structures. There is also a sense of disempowerment.

The Hospital Executive Committee does not have a lot of power because it does not have control over funding. It distributes the funding which it gets which is inadequate in the first place. ...I wonder if they (health board management) are just pretending to involve us in management.

Clinician

Yet there is a view at health board level that clinicians in this hospital are fully engaged in the process.

There is more ownership by clinicians in some places– for instance in Northop they are very good – in Southop not very good, and in Easthop not so good. I think it probably has to do with other agendas in the external environment around threats to closure,... let's pull together and so on, so I think they have to be factored in. And I think there is a lot of loyalty there as well among the clinicians and credit to them for that. There is a lot of loyalty to the hospital there, and it's a bit easier to manage and deliver in a smaller setup.

Assistant CEO – area health board

There are a number of benefits resulting from the 'clinicians in management' initiative.

The biggest reward is that I've stopped sniping at them. I've realised that management is a very difficult job. Also I believe that there is a better understanding now at administrative level that the resources we are looking for are justifiable and I also believe that I am of more benefit to patients hurling on the pitch than on the ditch. I think that you can benefit patients far more being inside.

Clinician

When you look at the distribution of resources for the various services, you get very little as I perceive it if you aren't involved. I felt being involved I'll see if it will make a difference.

Clinician

Clinicians in this hospital have their own reasons for coming together with management, which include having a say in the distribution of resources. Whilst clinicians identified benefits from involvement in the Hospital Executive Committee, there were also costs incurred by that involvement.

I'm missing 2½ hours work every Friday morning, so financially there would be a cost depending on how work was going (the public/private mix)⁶⁹. Then there are informal meetings, things being sent to you because you're in management, you've got to read them.

Clinician

Clinicians and other hospital and health board staff concur in their criticism of the hospital accounting system, and its ability to provide them with useful information. This is explored in depth in the next section.

9.4.3 Use of accounting information

Unlike in the other three case study hospitals the accounting function at Norhop is located off-site and is operated by health board staff. In this health board the accounting function was decentralised in 1998 and since then has been based in the county for all care groups in the county of Nortville. It was decentralised at that time as:

The area health board management considered that it was too far removed from the decision-makers. We monitor their funds (the hospitals) and their staffing. We don't get involved in activity levels which is a disadvantage.

Financial Controller

Health board accounting staff are located across the town in a separate building, at a distance from the under-resourced hospital. The Hospital Administrator has official monthly meetings with the person who prepares the monthly accounting information for the hospital. The Hospital Administrator believes that this works very well:

I would be in regular contact with our finance people over there. ...She raises things with me before I'd even become aware of them myself. She'd know what's to go through in any month.

Hospital Administrator

⁶⁹ This refers to the arrangement whereby consultant hospital doctors employed by public hospitals are facilitated / allowed to operate a private medical practice within that hospital and charge the patient accordingly. See earlier discussion in chapter 6.

Accounting systems development is different across each health board and even across different geographical areas within the same health board.

In Nortville we have changed a lot, we have a budgeting system for our county. The other counties do something different.

Financial Controller

The accounting and financial information that the Hospital Executive Committee receives stays with the group of four. It is not circulated or disseminated to any other staff. However, whilst accounting information is not widely distributed, there is an awareness of the budget position by staff, particularly nursing staff, as the Director of Nursing shares some financial information with nurse managers at monthly meetings. This cost consciousness develops into Value for Money (VFM) initiatives, many of which have resulted in savings for the hospital:

Well I would be far more active now and involved particularly at the hospital executive level in looking at the overall hospital budget. I must say I have a very good nurse management team (two assistant directors of nursing, one relief assistant director of nursing, two night superintendents, and ten ward managers) who, after a number of years have become a lot more proactive in relation to budgeting themselves, and looking at products, particularly non-staff expenditure, to examine these for value for money ideas and projects.

Director of Nursing

Health board accounting staff, in conjunction with hospital staff, have developed a management accounting system for costing staff in each ward and unit in the hospital.

The system development arose because:

What we found was we were told we need 120 WTEs (whole time equivalent staff), we were paying for 120 WTEs but we were only approved for 108 WTEs, so we had to get out there and see for ourselves what the difference involved.

Financial Controller

There is a feeling of 'disempowerment' with the budget and the composition of the actual expenditure. Accounting information is not used to control expenditure by the person responsible for the largest group of staff in the hospital.

Well I don't have any direct control over the budget. I go to a monthly meeting that tells me you're x amount overspent or under spent, or your agency nurses bill is too high, or whatever. But in actual fact trying to get to the detail, the devil is definitely in the detail because we can never get to the detail of exactly how it's all made up. I don't find the accounting information particularly useful other than it just gives you a good idea about health care budgeting. We all know it comes with a price and it's always a good idea to have an idea of the price. But I can't identify exactly how much Male Medical (Ward) costs me.

Director of Nursing

The hospital is treated as one cost centre by the health board. There has been no development of cost centres for medical specialties within the hospital. This has led to a belief that it is difficult to instil financial accountability within the system.

We don't have cost centres for surgery or medicine, where clinicians are accountable for their actions and accountable for their expenditure. We don't have either directorates or cost centres established within the region so that makes it much, much more difficult to put accountability into the system. Accountability, if you ask me, is about trying to control the budget, the monthly report and it is clinically led.

General Manager- Nortville County

There is recognition that the accounting system and systems of accountability are weak and poorly developed.

The Brennan Report talks about accountability and clear lines of accountability and so on but that's all very well in theory, but unless you have the systems to deliver on that, it is not doable given the scale and size of the business that we are in, so until such time as the investment is made in the systems very little can change.

The problem, I think, is that the systems are not geared to delivering detailed information to local units. I mean all our finances are published on a monthly basis – they are available to the Board and it's not as if we are being secretive about anything. I think the problem is that the systems simply can't report on that kind of detail at unit by unit level.

Assistant CEO – area health board

Whilst the routine accounting information is not considered useful there is a widespread commitment to examine value for money projects in an attempt to make savings and improve efficiency from staff employed throughout the hospital – nursing, non-nursing and consultant hospital doctors. Despite the frailty of the hospital accounting system, NPM ideas are filtering through to the majority of staff in the hospital. The need for savings and efficiencies is well understood in the context of possible closures or at a minimum a change in status and designation for smaller acute hospitals as proposed in the Hanly Report (see chapter 6). In part these concerns have fuelled the drive for efficiency savings.

9.4.4 Value for Money Initiatives

Senior staff from several disciplines in the hospital proactively engaged with management's attempts to seek out value for money (VFM) initiatives, despite not understanding the routine accounting information received on a monthly basis.

Our infection control officer here has been looking at changing various products. The issues are: will the new product bring us up to an acceptable clinical standard and will it have a cost/benefit or a cost/negative effect? Then you're involved in making choices and decisions on that basis.

Director of Nursing

We actually looked at how we give our intravenous injections and we changed our way of doing it and achieved substantial decreases in cost. On the positive side, Tom (the hospital administrator) then bought a piece of equipment that one of the wards was looking for, for ages, with the savings. So they got a little trade back. We're trying – there's been a change – it has taken a number of years and it's still not completely refined, but we're getting there.

Director of Nursing

VFM initiatives are not just confined to nursing, some have also come from the hospital administrator and consultant hospital doctors.

We brought forward the management of respiratory failure for example to a very modern way of doing it from a very old-fashioned way of doing it. We explained to him once (to the hospital administrator) that you have the capital expenditure which came to about 90,000 euro. We showed him how over a period of about 6 months the usage costs – the disposables – would be about one-fifth of what they were so you'd have your money back very quickly. He had no problem whatsoever in financing it. All you need to do is explain it in money terms, and even though he may have a capital outlay, he would come up trumps if it seems worthwhile.

Clinician

I find most of the focus on value for money is about getting things cheaply, but there's another side to getting value for money that we're all supposed to be at: providing an efficient, reliable, valuable, prompt service – that's the important aspect of it for me. I notice in most discussions it rarely gets any credence. It's like numbers, people are jumping up and down about efficiency – what are your numbers, and we've had this with bed-stays. Well do you know what gives your bed-stay the best outcome? The patient comes in, gets checked in, gets into bed, and dies in only four hours. They cover up for a lot of over-stays to get your average down to 3.x days.

Clinician

The pharmacy expenditure is the largest non-pay cost for the hospital and new systems have been introduced to improve control.

In the past stores were contacted by everybody and anybody to order everything and anything that they wanted. There was no checking system there. Now we're stringent about it. The practice now is that new products are not approved until I sign off.

Hospital Administrator

This includes items such as new drugs that a consultant hospital doctor might prescribe. The evaluation of therapy change is therefore taken with both a clinical and cost consciousness perspective.

Significant expenditure on drugs would go through me if it has a major cost and I will discuss it with the consultant involved. However, this does not mean that we always

go with the cheapest drug. For instance, things like drug X which we ended up introducing for patients with MIs [a medical condition]. We were using Drug Y which is still in use in other hospitals, but for clinical reasons, we agreed to bring in Drug X here. Now it's four times more expensive, but there is a huge clinical value to someone who gets this on time. We were able to identify some money from the cardiovascular strategy, that we were able to put into the pharmacy budget to offset it.

Hospital Administrator

When it was queried how far the increased clinical benefit / increased cost trade off went in the decision making process the hospital administrator noted:

Well, yes, ok, there is one drug I've said No to. It's a very very expensive drug for (condition X). ... There are other drugs which may not be quite as effective, but are still effective and they are in use elsewhere. So until I'm funded for it I won't agree to bring it in.

Hospital Administrator

The accountability legislation is clearly impacting on this hospital as the need for adherence to annual budget overrules clinical criteria for drug therapy selection. When it was remarked that it was unusual that a hospital manager has been able to influence the choice of drug:

Well when there's a cost there, there's times you have to say yes and no to these things. There are not unlimited resources. In fairness, when you have consultants on the Executive – you do get support. I think that's very important, and by and large, in comparison maybe to some of the other hospitals around the area, there is very very good support from the consultants in this hospital. You will have difficulties with them on different issues but that's part and parcel of the job.

Hospital Administrator

Non financial information is gaining increased visibility with the requirement of the area health board to return it on a quarterly basis to the DoH&C. This includes information on progress on waiting lists, out-patient services, equity/access, use of acute sector beds and accident and emergency department statistics (see Appendix K).

9.4.4 Implications of efficiencies achieved

There has been a failure to develop the budget to reflect increasing demands on nursing resources, who account for 45% of hospital staff (Department of Health & Children, 2005). The WTE allocation process for nursing staff does not reflect advances in medicine, medical technology or additional pressures caused by the increased focus on efficiencies sought by both the DoH&C and the area health board.

The length of stay has reduced. Therefore the workload in trying to turnaround patients has really increased. So we've had to increase staffing even though we've

never been given a budget for it, because they just couldn't cope with the pressures at ward level. The staffing levels here were designed in 1979 and they haven't been revised. They were based on a length of stay of 17 days. Now a length of stay is down to 5.6 days. Therefore you have a lot less time to do the same amount of base line work and get patients turned around and home. More and more patients are coming in as well, so it puts a lot of pressure on admission and discharge.

Activity is increasing. The scope of what we actually do and what medical science is now expecting as a base line is very different to what medical science 15 years ago demanded as the base line. Your blood pressure and temperature might have been taken once a day 15 years ago, depending on your condition, now it could be an hourly task.

Director of Nursing

Decreasing length of stay and advances in medical technology and expertise have resulted in increased activity and pressure on all resources but particularly nursing staff resources. An increasing range of diagnostic services are responsible for increased activity and turnaround of patients. This has resulted in additional pressures on resources at the hospital, which has manifested as approval for only 108 WTEs (wholetime equivalent posts), whilst requiring 120 WTEs to operate at safe nursing care levels for the twelve months to October 2003. This has resulted in negative cost variances month on month. Whilst there have been attempts to embrace NPM ideas in practice in this hospital, implementation has not been without difficulty, as discussed below. Decreasing lengths of stay and an increase in activity are outcomes promoted by NPM type ideas.

9.5 Discussion and Conclusions

There has been an attempt to replace highly centralized structures with more decentralized management environments in sectors adopting NPM principles (Hood, 1991; Aucoin, 1995; Hood, 1995b; Pallot, 1997; Borins, 1998; Guthrie et al., 1999; Jones & Thompson, 1999). There is a new management structure at the apex of Norhop hospital in the form of the Hospital Executive Committee. This has meant that there is now a link between the on-going management of the hospital and the Medical Board which represents consultant hospital doctors. However, there has not been a simultaneous devolvement of discretion over the use of resources. Without increased

discretion over the use of resources there is little scope for active management of resources. Barzelay (2001) argues that a prerequisite for delegating managerial authority is a running costs system that permits operational managers discretion in the use of resources. This discretion is absent. The organizational structure changed but the financial management systems changed little. Where there is discretion over the use of resources at hospital level, it rests with the hospital administrator, not with the Hospital Executive Committee. There is also little control over activity as 80%-94% of admissions are emergency admissions, depending on the time of year. Despite this, there is a willingness to engage in the management process, by clinicians and the director of nursing. Despite the frailties of the accounting systems, clinicians have worked together with management to pursue NPM type objectives.

There is an increased awareness of cost reduction and efficiency objectives throughout the hospital, evidence of the NPM (Plowden, 1994; Lapsley, 1999; Abernethy & Lillis, 2001). This has resulted in improved cost control and an active search for value for money initiatives which are key elements of NPM and NPFM as noted by Guthrie et al. (1997). The greatest sharing of financial information has been with nursing staff and since they represent a large proportion of hospital staff, and work in every part of the hospital, this awareness of the need for greater efficiencies is dispersed throughout the hospital. This observation supports Hood's assertion that NPM has a much greater impact on front line delivery units (Hood, 1995b). Nurse managers have picked up and run with the NPM ball in this hospital. They have assisted in dissipating the NPM message to staff throughout the hospital. The hospital administrator in this hospital adheres avidly to the requirements of the HAA 1996, and the director of nursing as a member of the management team, is influenced by this strong support for NPM initiatives. Whether nursing staff in this hospital see themselves as "administrative leaders" as opposed to "experts in caring", and accepted managerial reform initiatives in the belief that their new position offers greater "acknowledgement" of their position relative to that of the medical profession (as in Blomgren's (2003:66) Swedish study) is unclear, as it was not the focus of this study. Whatever the motivation, nurses in this

study have shown a willingness to accept greater responsibility for resource management even if it is not properly funded and accompanied by discretion and authority, as was the case in the Purdy (1993) study.

Financial management information systems providing detailed costing of staff information were developed to justify consistent overspends in nursing pay costs. Such development of accounting systems to “make sense of budgets after the event” is seen as a “legitimizing function, in which accounting figures are assembled to project a defensive shield over the activities of the core – the health care professionals” (Kurunmaki et al., 2003:136). On this occasion the health board financial controller of Norhop undertook the new staff costings in an attempt to understand the need for consistently paying 12 additional nursing WTE’s. A new staff costing system was developed in conjunction with senior nursing staff at Norhop. Such a willingness to get involved in understanding the additional budget need may be seen as placing the financial controller “as a defender of clinical practice” (Kurunmaki et al., 2003:136). In such situations accounting staff are not seen as threatening but as attempting to defend excellence in clinical practice in situations of constrained financial resources (Kurunmaki et al., 2003).

However, the primary objective of the hospital financial management system is to satisfy the requirements of the DoH&C. The system has been developed for this purpose and is inflexible in producing information for other purposes. Attempts to develop new forms of accounting information are primarily to justify overspending on pay costs or to justify additional resource requests. This was illustrated earlier in the case of the WTE approved allocation for nursing staff. The historical allocation does not take account of improvements in medical technologies, additional pressures caused by reductions in length of hospital stay, and quicker turnover of hospital beds – all efficiency outcomes of the NPM. Attempts to develop performance indicators have been slow. While it is part of the service planning documentation, many departments ignored this in service planning for the forthcoming year, as evidenced in a sample of service plans reviewed.

There has been no attempt to develop accounting information on a clinical basis. The hospital as a whole is viewed as one cost centre despite the preparation of service plans across more than twenty units within the hospital.

The continued use of the existing accounting system means that it is impossible to trace costs to specialties. The lack of a flexible financial management information system together with limited discretion over resource use means that the 'clinicians in management' structure is ineffective and impotent. However the response in this hospital to the frail accounting system has been different than in the other hospitals in this study. Many staff have engaged with the service planning process, the hospital's administrator is enforcing the requirement to adhere to the "accountability legislation" and all staff have engaged in the search for VFM initiatives. In part the high level of "buy-in" to NPM type ideas, despite the fragile information systems support, and the search for efficiencies may be fuelled by The Hanly Report and by a fear, which was ultimately realised when the report was published, of a proposed regrading of the hospital from general hospital to local hospital status. However, as the hospital is not in casemix funding, because of its small size, there are no opportunities to benefit from positive casemix budget efficiencies adjustments.

Consultant staff engaged with management in the hospital and health board since 1999. Motivation for the involvement of consultant medical staff in a 'clinicians in management' initiative may have been fuelled by both a concern for the continued viability and future of the hospital and a desire to seek additional resources for their speciality areas. Involvement of 'clinicians in management' has been very slow to progress in the large acute hospital in this health board area, despite the efforts of the health board and hospital management to engage consultant hospital doctors there since 1998. One outcome of the 'clinicians in management' initiative in Norhop is that clinicians appreciate the difficulties experienced by the hospital administrator in managing the hospital. This outcome is positive and concurs with Maddock and Morgan's (1998) argument that the future lies in professional and managers coming to

recognise each others value and negotiate more balanced relationships. The future for public sector organisations relies on staff moving beyond professional tradition and bureaucratic practices. However, advances in other areas such as resource allocation mechanisms are also required.

The resource distribution system is based on historical allocations with adjustments for inflation and additional development monies (if any). This system does not facilitate a link between resource allocation and activity. Enforcement of the HAA 1996 has increased the awareness of hospital consultants, nursing and paramedical staff about the link between resources and activity. There is now an explicit quantification of planned hospital activity – the annual service plan. However, the main focus of the service plan is on the second of the two requirements in the HAA 1996 – to deliver the agreed service plan within the approved financial resources allocated. The preoccupation is with delivering whatever services are possible within agreed budget limits. There is clearly an increasing emphasis on financial accountability, as noted elsewhere in implementation of NPM (Ezzamel & Willmott, 1993; Lapsley, 1999). There is also an attempt to balance efficiency and effectiveness measures as advised by Abernethy & Lillis (2001) and as illustrated in this case study by the non-approval of the pharmaceutical drug choice of a hospital consultant. Whilst the budget limit is only an economy measure, the service planning process is directed at improved efficiencies by requiring staff to re-examine on an annual basis their use of existing resources and to seek new ways of making better use of the same resources. Performance indicators of a non-financial nature endeavour to direct resources towards improved effectiveness outcomes. Return of non-financial performance indicators is now required by the DoH&C. A list of non-financial performance indicators for the acute hospital sector listed in the annual area health board service plan for 2003 is provided in Appendix M.

Despite the involvement of ‘clinicians in management’ the present system still emphasizes functions and centralization, as noted elsewhere by Thompson (1997). The involvement of clinician staff in management in this hospital was relatively easy. This

might appear to contravene Ouchi (1977) and Abernethy & Stoelwinder (1995) who suggest that clinicians prefer to work unencumbered by non-clinical accountability mechanisms. However, though they have involved themselves in the management initiative they have done so reluctantly. They are now less distrustful of the local hospital manager. This change in attitude has come about from participating on a weekly basis in a hospital management meeting where operational challenges facing the hospital administrator are discussed. However, they are still distrustful of management intentions at the health board. The empowerment, feedback and collective management decision-making that are necessary for developing trust and delivering positive organizational outcomes (Nyhan, 2000) are missing components of the Hospital Executive Committee structure. Little has changed apart from engaging the doctors in management. Their appreciation of the difficulties the hospital administrator faces in running the hospital has grown. Yet there is little they can do to change the current position. Control of financial and human resources is decided by the DoH&C.

The proposed changes required by The Hanly Report will require new organizational structures. Current and projected population statistics do not support a justification for remaining as an acute hospital (Department of Health & Children, 2003e). A change from acute hospital status to local hospital status is likely. Structural reorganization is particularly corrosive of trust in management (Morgan & Zeffane, 2003). Clinicians have already engaged in a management initiative that was not well supported by the health board or DoH&C. The "let the managers manage movement" (Kettl, 1997) has not taken firm root in this hospital. There is still a bureaucracy, limited systems development and severely limited discretion over the use of resources. There is a mismatch between the corporate message and the internal systems required to deliver that message. The system is turning slowly to encourage performance.

Changes to the accounting system have not matched changes in management structures. Financial support for accounting systems development to improve financial reporting has not been forthcoming. What changes there have been to the accounting system are

focused on discharging managerial accountability. The new organisational management structure is impotent without the necessary system developments to support it. The consultant hospital doctors have engaged with the management process and while this is regarded as an achievement, the primary benefit has been of one of increased understanding of the difficulties associated with management of the hospital. Consultant doctors have moved beyond the boundaries of professional tradition but the bureaucratic practices are still strong. Lack of financial systems development has resulted in a continuation of bureaucratic practices exercised from the centre – from the DoH&C and the health board. Few other benefits have emerged as the institutional system of the health board does not support further development of organisational structures or devolution of resource management.

There is but weak evidence of NPM in the management of this Irish hospital, unlike in Australia, New Zealand and the UK, where there is evidence of substantial changes in the nature of financial management information systems coinciding with changes in public sector management generally (Schick, 1990). The tremendous emphasis on new accounting procedures observed by Pollitt (1988) in countries adopting NPM type reforms is absent here.

December 2003–	100%	74%	10.1%
January 2004–	100%	75%	10.2%
December 2003–	100%	74%	10.1%
January 2004–	100%	75%	10.2%

Source – DoH&C (2003)
DoH&C (2004)

¹⁰ This category of staff includes all staff who are employed by the hospital, including those who are employed by the hospital but who are not employed by the hospital. This category includes all staff who are employed by the hospital but who are not employed by the hospital. This category includes all staff who are employed by the hospital but who are not employed by the hospital. This category includes all staff who are employed by the hospital but who are not employed by the hospital.

CHAPTER 10

SOUTHOP CASE STUDY

10.1 Introduction

This case study hospital is a relatively large regional acute public hospital. The NPM literature together with the literature on the professions and organisational trust (chapters 2 and 3) will be drawn on to develop explanations for the manner in which NPM ideas have been and continue to be introduced in this hospital. Like the other case study hospitals, it is subject to influences from a variety of sources, among them the area health board and the DoH&C. The hospital is called Southop and is located in the county of Soutville. It is part of a health board comprising three counties: Nortville, Soutville and Eastville. Details of staffing in Southop are provided in Table 10.1 below, which shows that there has been a significant increase in the ratio of management/administrative staff to total staff over the three year period to December 2003.

Table10.1: Staffing Statistics for Southop

Year	Total Staff	Management/ Administrative Staff ⁷⁰	Management Staff as a % of total staff
December 2000~	1408	197	14.0% ⁷¹
December 2003+	1746	257	14.7% ⁷²
Growth in staff December 2000-03	24%	30.4%	

Source: ~ DoH&C (2001b)
+ DoH&C (2004b)

⁷⁰ This category of management/administrative staff includes such staff as hospital consultants' secretaries, community welfare officers, out-patient department personnel, ward clerks, medical records personnel, telephonists and computer personnel who are engaged in front line duties.

⁷¹ This compares with 12.5% for management staff as a percentage of all staff in all acute hospitals in the other area health board (see Table 8.2) in December 2000.

⁷² This compares with 15.4% for management staff as a percentage of all staff in all acute hospitals in the other area health board (see Table 8.2) in June 2003.

Acute hospital services in this health board area are provided on six sites: at Southop, Norhop, Easthop and at two other specialty hospitals providing orthopaedic and obstetrics/gynaecological services, and also at an independent voluntary hospital with close links to the area health board. Southop is the designated regional and trauma centre. Activity at the hospital as measured by in-patient admissions, day cases and casualty attendances continues to grow (see Table 10.2).

Table 10.2: Activity Statistics for Southop

	No. of in-patient beds available	In patient admissions	% occupancy ⁷³	Average length of stay (days)	Day cases	Casualty attendances
1994 *	345	21,222	93	5.5	3,470	50,410
1997 #	355	21,622	93	5.6	7,134	57,117
2000 >	341	20,857	98	5.9	11,900	56,375
2003 +	419	not available	89	5.8	17,804	51,515

Source: * DoH&C (2000:147)
 # DoH&C (2003b:170)
 > DoH&C (2003b:176)
 + Information supplied by the DoH&C (2004d)

Day case activity has increased dramatically in line with increases in other hospitals. The upgrading and opening of new clinical facilities on site, together with changing clinical practice, has facilitated this move. Prior to the opening of upgraded and new facilities the bed occupancy ratio was dangerously high, a factor which impedes the most efficient and effective use of resources.

The case study research design is as outlined in chapter 5. This study gathered evidence from a variety of sources: internal and external documents, some limited observation and interviews. An unstructured interview methodology was used to address the research

⁷³ As noted previously “the internationally recognised measure of full occupancy is 85%”. DoH&C (2002:10).

questions (as outlined in chapter 5). In total seventeen interviews (see Table A6) were conducted with sixteen hospital staff during the period April 2003 – May 2004, whilst three interviews were conducted with staff at the area health board (see Table A5). Interviews lasted between one and two hours. Reports and sample accounting documentation were collected and analysed. Data on the case will be presented under the following headings: new management structures (section 10.2), new institutional arrangements (section 10.3), the role and use of accounting information section (10.4), and accountability and performance measurement (section 10.5). The case study data, together with the literatures that may offer a conceptual perspective, will then be discussed to develop explanations for the current status of management and accounting at the hospital (in sections 10.6 and 10.7).

10.2 New Management Structures and Institutional Arrangements

Hospital management is the responsibility of the interim management group (consisting of the general manager, the deputy general manager, the director of nursing, the financial controller, the human resource specialist and the maintenance and general services manager) who are responsible for operational decisions at the hospital. Attempts to engage clinicians in a clinical directorate model have been ongoing over the past six and a half years and are outlined below. At present there is a stalemate. The interim management group meet weekly on Tuesday afternoons. Paramedical staff such as physiotherapy, pharmacy and staff in the laboratory have never been invited to join and consultant hospital doctors, though invited, do not attend. Agendas for weekly management meetings are decided by the general and deputy general manager.

In October 1998, a Hospital Executive was set up. Local hospital management (including the assistant CEO of the health board, with responsibility for acute hospitals) sought consultant doctor representation on the Hospital Executive and this was forthcoming. As part of the last consultant doctor contract negotiations in 1998, it was agreed that clinicians would play a role in management (see Appendix N). In many hospitals various models for engaging ‘clinicians in management’ have been developed

and are considered to be working well (Office for Health Management, 2003). In Southop the initial clinician/management group, known as the Hospital Executive, comprised seven members: the general manager, the deputy general manager, the director of nursing and four medical representative nominees from the Medical Board: one surgeon, one physician, one anaesthetist and a pathologist. The group met on a weekly basis from October 1998 until October 2000 when it disbanded. Management believed that the hospital executive would have been “a sort of a pre-cursor to the directorate model”. Clinicians noted that they had tried to make the initiative work:

We made a lot of recommendations and so on about piloting clinical directorates. On multiple occasions we suggested starting a theatre directorate and in my opinion the senior management, the CEO [area health board], and assistant CEO just weren't interested because they had their own idea of how they wanted it to happen.They had surgery and medicine as two directorates...that's practically the whole damn hospital. How were we going to get someone to run that? Clinician

The group reconvened fifteen months later in January 2002 with again seven representatives, but this time the assistant CEO of the health board with responsibility for acute hospital services replaced the deputy general manager on the Hospital Executive. The group met for a period of six months, until July 2002, at bi-weekly meetings to agree templates in relation to the number of clinical directorates that would be required and the composition of those directorates. Whilst there was failure to agree on a clinical directorate model for the hospital, there is acceptance of the increasing role of private sector management ideas by some hospital consultants and a recognition that the nature of the clinicians' environment is changing:

Medicine is a combination of art, science and business and at any one time something is changing, the diagnostic arts are gone, there is a machine for everything now, science is taking over and business is starting. Clinician

There is also recognition by some clinicians that they have a large degree of power:

We have a fair bit of power here in Ireland. I think in Ireland, unlike in other countries such as the UK and Australia, we are all little kings and queens. We have the power to spend money but we are not accountable for it. However, I would consider clinical accountability a reasonably strong method of accountability. Clinician

An impediment to the involvement of clinicians is the loss of clinical time which, depending on the speciality, can translate into lost private income. Given the

public/private mix of patients in public acute hospitals in Ireland (see chapter 6), there is a significant opportunity cost incurred by most hospital consultant doctors who participate in hospital management. They forego financial rewards from treating private patients during this time.

A new paramedical management group formed in the hospital in 2003 – the Allied Health Professionals Group – to represent the views of this disparate group who are not represented on the senior management group. The hospital general manager rarely attends these group meetings. The group formed in frustration after several service developments came on stream without consultation of the impact on allied health professionals services. Examples of this include an expanded orthopaedic service which would have a direct impact on physiotherapy services and an expanded oncology service which has had an impact on hospital pharmacy services.

Despite the formal resistance to the ‘clinicians in management’ initiative there are some consultant hospital doctors who input financial costs informally into their clinical decision-making (as evidenced below) and who are prepared to change products on a cost basis, provided the clinical benefit is the same, for example:

I know that the bicarbonate containing solution is twice the price of a non-bicarbonate containing solution, and I use the non-bicarbonate containing solution unless there is a good reason for using the bicarbonate containing solution. Clinician

There is also awareness and acceptance of good financial management practices among some clinicians and an attempt to limit costs. Consultant doctors who have worked in other countries, such as the USA, are aware of differences in the cost of different clinical treatment approaches. However the accounting system is inflexible in developing new costing approaches to support such understandings:

I have no problem with someone saying to me ‘look you have two or three ways of treating this condition, can you do a cost benefit analysis and decide on that basis’, I have no problem with doing that. I’ll do the studies. I have done those sorts of studies. Clinician

Both the general manager and deputy general manager are certain that the only way to improve the management of activity and activity levels at the hospital is to engage

consultant hospital doctors in management. They are critical of the gamesmanship, as they call it, of those responsible for patient discharge and admissions.

Despite the extra 61 beds that came on stream in this hospital last year, we recently had a situation where we had 20 patients waiting in the A&E. Now am I to assume that we would have 81 patients waiting? So it's critical that the people who manage the throughput of patients in the hospital are involved because they are the people who control activity here. The people who control what goes on and what doesn't go on here are that group [consultant hospitals doctors] and that is why it is so important to have them involved in management. For example, some consultant doctors might behave like this :

I can't guarantee that I can bring 'Mark' into hospital tomorrow to do his surgical procedure because I don't know if there is going to be a bed or not. But 'Joe Bloggs' is in today, so I keep 'Joe Bloggs' in and when he hops out of the bed, I will have 'Mark' ready to hop into the bed and that is the only way I can ensure I have a bed. Otherwise, the physicians have everybody brought in as emergency medical admissions. So 'Joe Bloggs' may not have required to have been in a bed, he could have been discharged the previous day or two days perhaps, but because I don't have an operating list until today I couldn't let him go on Monday or Tuesday because somebody else might have popped into the bed.

So there is this sort of management happening. It's not management, it's crazy behaviour but these are the sort of games that people feel that they have to play.

Hospital Manager

This behaviour results from the historical development of hospital consultant involvement in Irish hospitals. Many consultant hospital doctors operate a private practice within the hospital where they are employed, using the support staff and services without charge. This form of resource management by clinicians greatly impedes the efficient management of hospital resources in line with NPM principles and the current Health Strategy (Department of Health & Children, 2001a).

A clinician admitted that this type of 'bed-blocking' practice did go on in the past but was no longer an issue:

Forty five per cent of the population have private health insurance, there is an endless supply of private patients waiting to be treated. Bed blocking happened in the 1960's when consultants who were holding onto their VHI [private insurance] patients wouldn't let them go home. Bed blocking now means the poorest and the sickest aren't being sent out to nursing homes in the public sector, because there are not enough places. ... That's the bed blocking that's going on now. Clinician

Part of the reason for the failure to develop and implement the 'clinicians in management' initiative has been a problem of trust. There is widespread agreement that

an impediment to resolving the issue of consultant doctor involvement in a clinical directorate structure is trust. Yet trust is a vital component of every interaction system (Blau, 1964; Simmel, 1967; Lane, 2000). It is generally earned and grows at a painfully slow pace (Gilbert & Tang, 1998) (see discussion in chapter 3):

It is my impression that there is a lack of trust between the two groups [consultant hospital doctors and hospital management].
Clinician

I don't think the current administration see the Medical Board as having any relevance except to rubber stamp decisions they take and that is why certainly there is a lack of confidence and trust between the current Medical Board and this current administration [both hospital managers and health board assistant CEO with responsibility for acute hospitals].
Clinician

Antecedents of trust, as noted earlier, include communication climate, job security, perceived organizational support and procedural justice (Carnevale & Wechsler, 1992; Albrecht & Travaglione, 2003). Openness of communications was also noted earlier as an important determinant of organisational trust, since trust can be developed through increasing the quantity and/or quality of communication exchanges over time (Blau, 1964). By linking trust to communication one can start to ascertain the means to develop trust, even in situations where disparate partners are brought together (Hardy et al., 2000). The absence of trust can have negative consequences for the performance of the organisation (Carnevale & Wechsler, 1992), for example:

The consultants have fallen out with the management group. They walked off the Hospital Executive. That is why we now have an Interim Management Group. They [consultants] had concerns over trust and control. They [consultants] know that there are no devolved systems. They know there is no accountability so they see it really as administrative management pushing the accountability on to them but not giving them the tools – the budgetary systems, the appropriate supports and the appropriate budgets to make the decisions.
Director of Nursing

One consequence of an absence of trust in an organizations includes a cynicism towards change (Andersson & Bateman, 1997; Laschinger et al., 2000), as individuals who distrust the system almost feel obliged to resist (Culbert & Mc Donough, 1986), for example:

I am always a bit suspicious that somebody will try and screw me in management.
Clinician

I am the only professional on the Interim Management Group. The paramedics are not on it. I would see it very much as them and me. I would see that very much because

they're the managers and I'm the only professional.

Director of Nursing

For the Director of Nursing, who has remained on the Hospital Executive when the clinicians left, there is a feeling of isolation.

A fundamental constraint on hospital management in Southop is that the hospital general manager and deputy general manager are bypassed by consultant hospital doctors who seek support directly from the CEO or assistant CEO of the area health board. Legally the accountability relationship of consultant doctors is with the CEO of the area health board under the Health Act 1970. Hospital management can then be bypassed legitimately by this group. The effect of this is an undermining of local hospital management of even very large hospitals. A clinician involved in the Interim Management Group confirmed that this is a difficulty with the current system of management, and this continued to be a problem during the short life of the Hospital Executive:

In fact some people even when the Hospital Executive was in existence by-passed it which was one of the problems with it.

Clinician

This "by-passing practice" operates at lower levels of management also:

The biggest problem in some areas in health boards is that they are not able to make the decision about saying no, sorry. Yes the requirement is there professionally but we can only do this amount of care because we have only this budget. That requires a very strong manager to say: 'You can only do this amount of care, because this is the limit of your care within this budget'. When I do this, consultants by-pass me and go directly to the senior hospital management to seek what they want. And more often than not they are told they can have it. And that to me is lack of support. What you need is the team, singing from the same hymn sheet, speaking the same language.

Director of Nursing

Despite the inability to advance the clinical directorate model with clinicians, hospital and health board management continue to advance it via new institutional arrangements.

10.3 New Institutional Arrangements to Introduce NPM Ideas

Despite the lack of agreement from consultant hospital doctors, the health board CEO with responsibility for acute hospitals, together with the general manager of the hospital,

have pushed ahead and appointed two business managers to clinical directorates in May 2003. It is intended that the clinical directorates will consist of a lead clinical director, a business manager and an assistant director of nursing. One of the newly appointed business managers is in the surgical department, the other is in the medical area. Neither business manager has any support staff because of a WTE ceiling imposed on the hospital by the DoH&C (see discussion in chapter 6). The DoH&C refused to sanction the business manager posts above grade VII which would have allowed the health board to open up the recruitment to staff outside the health board. Failing this the health board requested a “dispensation” from the largest union representing staff to allow them to recruit outside the ‘Common Recruitment Pool’⁷⁴ but this was also refused. Thus both managers have been recruited internally at grade VII. The result has been that they do not have business backgrounds or accounting or financial skills or experience. As stated by a hospital manager: “We advertised. They were the only two people that were qualified at grade VII level”. One of the business managers believes, almost two years after appointment, that “We are just another layer of management keeping problems away from the top table”.

There are no support structures and they already feel undermined and frustrated because of the contradictions in the system. Staff in their directorates seek resources from them that they are not empowered to grant. For example, one of the business managers explained how having sought to find financial approval for support staff for a new consultant, this was not only unsuccessful but undermined by hospital management:

I have a new consultant employed now in my directorate for over nine months. He has no resources – no registrar or house officer or secretary. For the last eight months I have been saying to him ‘OK prioritise your caseload, don’t bring so many patients into clinics – I’m working on acquiring resources for you’. That was the line I’d have got from my CEO [the assistant CEO for acute hospital services in the area health board] and my General Hospital Manager.Eventually he himself speaks to the assistant CEO (of the area health board) and then comes back and says to me ‘well the assistant CEO said I could have a registrar and a senior house officer.’ The Hospital General Manager advises me to go away and source them. With Hanly [the 2003 Hanly Report] we can’t employ any more non consultant hospital doctors (NCHDs). I speak to the medical manpower manager. Now I know very well before I ever went to her that the answer is no – no additional staff. That leaves deployment of existing

⁷⁴ See section 6.5.1.

NCHDs. I am not able to deploy resources because it is not within my power to deploy NCHDs.

So the frustration continues and he's going to be disappointed and he and I will continue to fight next week because my CEO or my General Manager is saying 'you can have this' and it's not within my power or even their power to provide it.

Business Manager.

This is clear evidence of systems design failures and blatant weaknesses in the attempts to introduce NPM ideas. The business managers have not been empowered to make decisions or redeploy resources. Whilst there is a justification for the division of the hospital into manageable service units to secure and utilise resources more efficiently (Blau, 1964; Blunsdon & Reed, 2003), these units then require mechanisms for integration, such as decision-making groups, methods of communication and consultation and formal plans and procedures. It is this support element of the framework that is still entirely absent nine months after employing these business managers. As noted by the business manager:

The emphasis in this hospital is on moving the problem, not necessarily solving it. Now the problem here for us is this – there is no place for us to move a problem. They are problems which are parked with us because they know we haven't got the resources to solve them. It's like a game of musical chairs. When the music stops whoever has it – well they are in trouble. Now from that perspective the arrival of the first two business managers has been a God-send for management, we are a new dumping ground. It's coming from above us from the administrative side and also from the consultants. To be fair nurse management aren't really dumping their problems on us. We would have been handed the odd smelly problem that they really didn't want to deal with but in general they work with you.

Both this example and the earlier example of the director of nursing who was overruled by management serve to show how the system undermines procedural justice concerns and employees' perceptions of fair processes. The latter are important determinants of positive attitudes towards acceptance of new institutional arrangement and processes (Lind & Tyler, 1988; Albrecht & Travaglione, 2003). Continuous negative experiences by staff of attempts to implement under-resourced management initiatives may undermine the implementation of new clinical directorate institutional arrangements in this hospital. Lack of support leaves these business managers feeling frustrated and compromised two years after being appointed.

Clinicians are not the only group who have concerns with the new structures. The financial controller who is a member of the management team has concerns about the ability of clinical directors to manage resources:

I think we are expecting quite a lot for these devolved structures or directorates or whatever we call them in the end. There is a danger that instead of let's say a forum of four or five people looking after the hospital budget, that what you will have is the spend of that budget given to groups without any great responsibility taken by those groups, particularly in relation to the overall hospital budget. You could find a group saying I am fine, they would be within their budget. If other groups in the hospital have problems you won't find a group contributing anything towards it, so I think there are dangers in that.

Financial Controller

The move to decentralised management requires a change in attitude from all staff and will also require either training of those internal staff with new management responsibilities or the recruitment of staff as business managers with appropriate resources management experience. Accounting information is a key management tool of private sector managers and is seen as a "key element" of NPM reforms (Hood, 1995b).

10.4 The Role and Use of Accounting Information

The central area health board finance function was partly devolved in 1998, to four unique areas within the health board: to this large acute hospital and to the non acute services in Soutville county, Eastville county and Nortville county. The hospital financial controller reports directly to the general manager of the hospital and to the Director of Finance at area health board headquarters by means of a dotted line reporting relationship. There are 24.5 whole time equivalent staff (WTEs) in the accounting department. The majority of staff are involved in processing information – debtors, payroll and accounts payable. In addition to the financial controller (a grade VIII staff position) working in the management accounting information function, there are two grade III staff (the entrance grade for staff), and a half-time grade VII staff person. When the present financial controller was appointed in 1998 he moved from a role as management accountant at the area health board to financial controller at the hospital. The intention was that there would be an increased emphasis on management accounting

information from then on. However, as there were a number of difficulties with the hospital payroll information system, time was spent addressing this

Coming from central finance, there was a general level of dissatisfaction between central payroll and the payroll office here as to the quality and timeliness of returns, so we spent quite a lot of time turning that around. Financial Controller

The result has been less development of local management information systems: “Unfortunately you still are looking at the same set or style of management accounts as were here four years ago, the same detail” (Financial Controller).

Presently there is little sharing of financial information with key stakeholders in the hospital – for example the A&E consultant in charge receives nothing and neither do the clinical nurse managers in A&E. Involving hospital doctors in management requires a greater sharing of financial information which is relevant, timely and accurate (Yeatman, 1994). To bring about change it also requires engagement and a willingness to work with the information provided. However, the basic requirement of public sector managers charged with greater accountability is useful information. That is not available in this hospital. The chief physiotherapist does not receive any financial information, neither does a head of speciality/discipline:

Accounting information – we don’t get anything, we get numbers, numbers of patients and numbers of procedures, targets for the year and how you are doing up to that point in time, how many you have done. We get no financial information, zero.

Head of Discipline

Work at the hospital is increasingly technically differentiated as medical technologies are developed and new consultant appointments made. High levels of technical activity require co-ordination and control mechanisms (Blunsdon & Reed, 2003). Part of the way to control activity is to record and cost it. However, the accounting system in this hospital does not match the technical system of clinical work. Neither does it match the structure of organisational units used for the planning of activity in the hospital. The accounting system runs parallel to the organisational structure and is quite separate and distinctive:

One of the greatest challenge in my job is the systems that can’t provide you with relevant financial information and constantly battling and trying to search for that information.

Director of Nursing

The accounting system is centred around the needs of the DoH&C for audit and probity. The monthly financial reports which are returned to some staff in the hospital and to the DoH&C record expenditure under two headings – pay and non pay costs. What is required is less rules and procedures to ensure probity and compliance and a more intense focus on performance measurement (Osborne, 2000). The small changes to the hospitals accounting system are driven by the DoH&C.

The Department of Health are now requiring different things from regional health boards as to what they are reporting. They are putting more emphasis on the projections to the end of year rather than an account of historical happenings. They want more reassurance from health boards as to what is going on and what the end of year position will be.

Financial Controller

Stewardship and a limited form of accountability dominates the nature of accounting. This is not going to help hospital or directorate managers. This is a fundamental constraint on NPM taking hold. The accounting system is determined by external agencies and has little capacity to produce information which is useful to managers. Each month the hospital generates financial information to facilitate the preparation of the integrated management report (IMR) which is forwarded via the area health board to the DoH&C. The focus of the accounting system is on financial reporting not on information for cost management and control.

Look at the management accounts, for example you will get nursing in its totality, you'll get housekeeping in its totality but there could be four managers managing different components of the housekeeping budget. ...You know in your own head that you are a good manager, but the one who is a poor manager is diluting your good management but that is not evident because of the accounting system. I need that breakdown of information. Now the excuse that will be used will be our financial systems can't accommodate that and that the Board has outdated financial systems. I have been hearing this for years.

Director of Nursing

This is an instance of the information being too aggregated, and too distorted to be relevant for management planning, and control decisions, an observation made by Johnson and Kaplan (1987) in their study of private sector accounting systems. Hospital management are asking staff to control costs but are not providing the financial information systems to facilitate this control.

I don't get financial figures every week. I'm lucky if I would get them every month or so. I get a huge comprehensive list of medical and surgical costs..., which really to me would mean taking a week off to interpret it.

Director of Nursing

Managerial accountability assumes the existence of an accounting control system to measure actual performance and compare it to expected performance (Collier, 2001). The financial information systems support is missing in this hospital. The accounting system is unable to provide financial information to facilitate management and cost control, even though this could be facilitated in some areas by a simple extension of the cost coding system.

I'll give you an example – I manage the training budget, it is €250,000 approximately. If I go to Dublin on a course, I incur travel expenses. A large cost associated with training is the transport. It should be possible to break down the travel cost and isolate the part of it that goes with the training courses. The health board systems won't tell me what travel expenses accumulated in the year as a result of training. They can't tell me. ...I think it is unacceptable that we would be spending a million for example on transport and that we can't break it down to manage it. Director of Nursing

This lack of flexibility of the accounting system to provide basic cost management information is frustrating for staff facing demands for increased accountability from hospital and health board management. There is an expectation of greater accountability, but working against this is tight establishment control exercised by the DoH&C at level one and by health board managers at the next level.

Budgetary information is not circulated even to key staff who have responsibility for managing large numbers of staff.

The bottom line is, I need to know what is my budget? We operate a budget on a – controlled WTE [whole time equivalent staff numbers basis]. The last time I was issued this was last July (2002), 740 WTEs and I have told it is being cut this year (2003). I have been told the Board is being cut but I haven't been told what I am being cut. But I am responsible for a very large fraction of the total WTE, so whether it is 10 or 20 or one or two that makes a big difference. How could they say I am over budget if they have not given me that control figure to operate under? There was a blanket of secrecy. [This interview took place in April, four months into the budget year]. Director of Nursing

There is peculiar form of accounting, driven by the needs of an external agency – the DoH&C. Some of the language of NPM is being employed here but little use is being made of an endless list of management techniques to support staff being held accountable for resource management as advised by Humphrey & Olson (1995).

There is a gap between the hospital managers' expectations of resource management and the ability of staff to actively manage resources in the absence of financial information.

Nurse managers in prior studies have experienced similar frustrations. In Covaleski & Dirsmith's (1986:210) study they noted that nurse managers were "constrained from gaining access to desired and what they considered to be necessary information". In Southop the constraint is the inability of the fragile financial information systems to provide useful information. Yet formal hospital management meetings require an explanation of variances in the absence of knowing the budget for the division. This leads to conflict and frustration on the part of senior nursing staff who have actively engaged with management for a number of years, sometimes as the only professional,⁷⁵ in the 'clinicians in management' initiative. The desire among nurses to be recognised as professional is "real" (Covaleski & Dirsmith, 1986:210). There are many nurses interested in changing the status and public perception of their "subordinate profession".⁷⁶ Nurse managers can play a significant role in the implementation of NPM ideas, as in previous studies it was demonstrated that ward unit managers "can attempt to influence nursing practice through a variety of uses of accounting data" (Purdy, 1993:295).

Senior nursing staff in Southop indicated that given that they already had responsibility for significant staff numbers, they were willing to accept responsibility for budgets also if they were allowed authority to go with this greater responsibility. This has resonances of findings in Sweden, where nurses accepted managerial reform initiatives, in the belief that in their new position as heads of wards that "their relation to the medical profession had been strengthened" (Blomgren, 2003:66).

There is rhetoric from management about the need for improved information yet they appear unwilling or unable to support development of systems to produce such information.

I think that there is a need to be able to provide the managers with meaningful information that they can take away and peruse and contemplate. We can't do that at present.

Hospital Manager

⁷⁵ Both senior nurse managers in Southop referred to themselves as professionals.

⁷⁶ See discussion of the "subordinate profession" of nursing in Abbott (1988:71-72).

Hospital management recognise the inadequacy of the accounting information system but there appears to be little incentive or perhaps capability to change it.

The way the accounts are presented here is just not conducive to proper management.
Hospital Manager

Is there an unwillingness on the part of staff in the hospital accounting function, hospital management, health board management and the DoH&C to address the inflexibility and deficiencies of the accounting system? The evidence indicates that there is definitely a lack of capability and lack of incentive on the part of all of these parties to address the weaknesses of the frail accounting information systems. There is also a resource issue which is the responsibility of the DoH&C. Yet there is a presumption in NPM that there is accounting information system capacity; as noted earlier accounting is seen as a “key element” of NPM reforms (Hood, 1995b). In this hospital NPM reform attempts are being made without considerable accounting information systems support.

The accounting system is also quite inflexible. It is difficult to make changes to correct errors.

What goes into that spreadsheet on day one stays in the spreadsheet even though I may be able to say it's incorrect but it does stay - it's not actually changed. Paramedic

Accounting information systems cannot support the new institutional arrangement. The systems are unable to match the responsibilities of the business managers of the clinical directorates. For example, the new surgical clinical directorate excludes orthopaedics, gastroenterology and gynaecology yet these are part of the surgical departments accounting reports. The information is therefore meaningless for management purposes.

For example, if I ask for figures this minute from the perspective of surgery I'm getting them but they are including gynae and they are including orthopaedics. ...I am talking about surgery as in the areas I have responsibility for. Business Manager

10.5 Accountability and Performance Measurement

A formal service plan detailing the services to be delivered by the area health board for the budget allocation has been required since the passing of the HAA 1996. The service

plan consists of two parts: a review of the current year and projections for the following year. The objective is that staff would re-examine their core areas of activity and existing resources, evaluate how well they are doing what they are doing and seek new ways to create efficiencies in the use of resources. The primary concern is to provide services but ensure that there are no financial overruns.

It is quite underlined to us that in spite all the detail in the service plan the first principle is that we come in at the end of the year in a financial position that is not overspent.

Financial Controller

This objective was referred to several times by other staff interviewed. The service plan contains the activity target but the overriding objective is to deliver whatever services are possible within the budgeted guidelines. There is therefore penetration of NPM ideas deep into the organisation despite the flawed accounting information systems and its inability to deliver useful information for managers. This is driven by the 'accountability legislation' and the requirement to prepare an annual service plan.

VFM practices are being forced upon the hospital.

The DoH&C has reduced this health board's allocation by something like €2.8 million this year (2003), and headed it up as value for money savings that will be generated or expected to be generated within the year. As we start the year we have lost a certain amount of money in our allocations. So in many ways what is styled as VFM is a very crude way of cutting the allocation.

Financial Controller

In this area health board, there have been additional consultant posts approved at the larger acute hospital over the past years. Some developments have been delayed and the monies used to shore-up operational overruns, thus resulting in a positive position at year end – a surplus. This method of financial management has been acknowledged in an interview with the financial controller of the area health board and in the health board's service plan in 2002, for example: "Overspends are offset by income buoyancy and savings in pay due to delays in filling some posts and completing developments" (Area Health Board, 2002). This position is confirmed by the financial controller:

This health board have been in the enviable position that they haven't had a deficit for the past four years. ...The Department has clearly indicated that there won't be any development monies for 2004, which in effect has been our bail-out for the last ten years. You see because you tend to delay developments, it meets core under-funding.

Control by the DoH&C is being extended in this way. There is also increased scrutiny to check that funding is used for its intended purpose.

There has been a tightening up on how we spend development monies assigned to us in the annual allocation.

Financial Controller

While there has been an attempt to develop the service planning function at the hospital, there is an absence of a clear link between budget allocation, services delivered and resources consumed. Part of the accountability framework is missing. There is no requirement for service plan holders to account for or explain negative variances in activity. Yet senior staff at the DoH&C consider that accountability mechanisms are improving accountability.

I think overall accountability has become much, much stronger in the system than it was before service planning and the first charge for an overrun has really helped in that regard.

Assistant Secretary, DoH&C.

There are clear inconsistencies in the views of staff at different levels in the acute hospital framework about the value of service planning. There are many clear accountability and control weaknesses in the system.

I think there is very little accountability. For example, and I always take my own immediate environment...I could sit here all day and do nothing. I could do my knitting or email my friends and if I signed on the dotted line, filled in forms, went to the requisite number of meetings and my service ticked over I don't think anybody would notice the difference. Why? Because I don't have regular review meetings.

Paramedic

Two factors contribute to the control and accountability weaknesses within the pharmaceutical accounting system: one is the line reporting relationship which the pharmacist has little input into, and the second is the large physical distance (1km) between the pharmacy and the staff who account for pharmacy expenditure at the hospital. For instance:

Nobody actually checks that the prices that we negotiate are actually the prices charged on the invoice.I don't have enough power to actually do my job.....I have never been at a meeting where the medics would be at the same meeting.

Pharmacist

Despite the close relationship between the expenditure on pharmaceutical drugs and clinicians' work, there is very poor formal inter-working relationships. This has led in

part to a feeling of disempowerment with the system. There is an inactive Drugs and Therapeutics Committee who have not as yet agreed a list of drugs for the hospital. Instead:

They [clinicians] use the drugs of whatever rep. has been in the hall two days before.
Business Manager

In some paramedical areas staff entering the system expected to be held accountable for negative cost variances and were surprised when this did not result. The chief pharmacist who commenced working in the hospital in 1999 and who is one of the few people who receives monthly financial information has never been called to a financial meeting with hospital management. She believes that there is little accountability other than what one brings to the job oneself. For instance, in her first annual total expenditure report at the hospital there was (and still is each year) a line for 'drugs out of date'.

Look at this line here 'out of date drugs' – we have never once been asked to account for... why we have thrown out €9,000 worth of stock and I think I should be having to account for every last penny and why I had stock that went out of date. Now when I first started recording drugs out of date, I was shivering in my shoes. Now I don't even blink an eyelid. Out of date drug expenditure for last year cost us €10,000 and I think I should be accountable as to why that happened.

Performance measurement at the hospital is underdeveloped. There has been a public outcry over lengthy hospital waiting lists and government have identified certain performance indicators as important, such as reduction of waiting lists and waiting times as a priority (see Appendix K) for acute hospital performance indicators for 2005).⁷⁷ However, there is a willingness by some staff to engage with more specific performance measures.

I think performance indicators need to be made department specific or area specific because okay we can use the standard ones such as the waiting times, the number of adverse incidents, the complaints – but for real performance measurement we need to develop these on a departmental basis and have them peer reviewed. One of the things that we have done is we have reduced our waiting list over the past few months from 600 patients plus down to current [zero]. So when a patient walks into outpatients they are given an appointment for within two weeks. We did that by validating the waiting

⁷⁷ As noted in chapter 6 the concern with hospital services translated into the election of six independent "health candidates" to the Irish parliament in the most recent national parliamentary election in 2002, (Houston, 2002).

list, by phone and post. Everybody on the team sat down, took a set number of patients, phoned everyone of them. The ones we did not get through to on the phone we wrote to them. There were just over 200 that actually still required treatment. Everybody in the department took an additional two patients a day on top of their current workload. We had a real blitz on it. I would see that as a very big performance measure. But nobody ever commented to me on the success of this. Chief
Physiotherapist

There are many impediments to the efficient running of any organisation and the development of accountability and performance measurement supporting structures. The significant issues surrounding the use of accounting information to manage in this hospital have been laid out above. In the next section a discussion of the impediments to substantial NPM reforms will be discussed together with some additional evidence to support these claims.

10.6 Discussion of Findings

Management of any organisation are concerned primarily with two issues: the planning of services/production and the delivery of those services in an effective and efficient way within the financial resources at their disposal. Planning of resources within the hospital system is now formalised under the HAA 1996. This has perhaps been the greatest visible change in management for most staff throughout the hospital since 1997. Their involvement in the service planning process has afforded them an opportunity to become involved in service planning and development. However, some staff see this as token involvement. Less than fully honest attempts to involve staff can undermine trust relationships and organisational commitment leading to negative consequences for the performance of the organisation (Carnevale & Wechsler, 1992).

In this hospital, there is little discretion over the use of resources and health board management are actively involved in hospital management. Where there was discretion in the past to use resources for other than their intended purpose, this avenue of discretion is being closed off by the DoH&C. There is a struggle to decipher who has control of resources in the hospital. It is impossible to make informed choices in the absence of information. Hospital management believe that it is doctors who control

activity and therefore the consumption of resources. Yet doctors believe that management are attempting to increasingly control their work. This picture of multiple managers is depicted by a senior paramedical staff person.

I would see Tom Browne [assistant health board CEO] as attempting to conduct the orchestra from the band stand but the consultants are up there with batons as well so that's where the power lies.

This concern with control in the hospital is linked with trust. The issue of trust is a critical one for management and staff at the hospital. Both management and clinicians doubt the capacity and willingness of the other group to deliver desired organisational outcomes. The financial controller, a member of the interim management group, is not fully convinced that the disaggregated organization will be able to manage itself as evidenced by quotations earlier in this chapter. Presently the only staff aligned with the two directorates are the business managers. The clinical directorate model cannot succeed without financial and management information systems support. Unless there is a development of financial management and information systems to support the new clinical directorate structure there is a danger that hospital management will continue to attempt to exert control from the centre and that responsibility and increased accountability for resources at clinical directorate level will not be accompanied by flexibility and discretion over the use of resources.

Trust is also an issue for clinicians. Maddock and Morgan (1998) have argued that a major obstacle to bringing medical professionals and management together tends to be a combination of a medical resistance to managerialism and the medical establishment's traditional codes of practice. This study claims that a further obstacle to reform is the absence of trust between management and clinicians. The lack of trust has been illustrated in this case. The general and deputy general manager noted many times how power and control rest with the consultant doctor group. Clinicians are seen as a powerful and influential group within this hospital system. They are the only group with admission and discharge rights. They have impeded the advancement of the 'clinicians in management' initiative at Southop. Not only are management seeking to draw clinicians into the active management of financial resources at the hospital but other

groups within the hospital are also seeking additional control. Murphy (1990) argues that professionals employed in bureaucracies are dissatisfied not only because they are controlled by bureaucratic administrators and state regulation, but also because lower ranking professionals, who were traditionally regarded as powerless, are beginning to seek some of the power of the well established professions.

The formation of the allied health professionals group to seek increased representation has been a development in this regard. Abbott (1988) argues that the major shift in legitimisation in the professions has been a shift from reliance on social origins and character values to a reliance on rationalisation of technique and on efficiency of service. This change reflects value shifts in the larger culture and has steadily pressured professions to move towards new legitimacy bases or face erosion of jurisdiction (Abbott, 1988). Medical treatment delivered within a large and differentiated division of labour is efficient organisationally. It is this rising value of organisational efficiency, a key objective of NPM reforms, which directly affects the relative status of professions by forcing many of them not only to become employed in such organisations but to partake in the active management of scarce resources. Though hospital consultants are resistant to 'clinician in management' attempts the directorate model is being pursued by hospital management.

Trust by superiors increases the likelihood that employees have access to more information (Laschinger et al., 2000). Yet this assumes that there is useful information available, an assumption similar to Hood's (1995b) assertion that accounting information systems design, capability and flexibility would be there to support the introduction of NPM ideas and practices. As they receive more information employees will trust more as they will be better able to judge management trustworthiness (Podsakoff et al., 1996). Therefore initiatives for building trust need to address issues of communication (Young & Daniel, 2003). As noted earlier, this has been shown to enhance trust significantly in service-providing settings (Podsakoff et al., 1996). A greater openness with financial information may increase the likelihood of the clinical

directorate initiative succeeding. However, this is a problem as the centralised control of accounting information systems in these hospitals through the needs of the DOH&C militates against supplying useful information that might engage non-financial managers.

A further problem militating against the involvement of 'clinicians in management' in Southop is that clinical time is intrinsically related to private practice. Clinical time in a public hospital involves treating private patients and public patients. As forty five per cent of the population have private health insurance, a clinician foregoing a theatre list, of which half of the list is private patients, incurs a substantial financial loss in addition to any clinical practice satisfaction loss from foregoing the clinical work for administrative/management work. This pressing financial reason for not engaging with management, together with concerns over both power and trust within the hospital, have lead to the present stalemate as regards clinicians' non-engagement with hospital management. Whilst there is anecdotal evidence that clinicians have engaged with management in many other hospitals, the fact that there is no private hospital in this city to facilitate private practice outside of Southop may also be a factor contributing to the lack of engagement. Essentially private medical practice, which does not require the consultant to travel substantial distance, must be conducted in Southop. A directorate model involving a small number of directorates would involve relinquishing current levels of control to a few key clinicians. This may be a contributing factor to the 'clinicians in management' stalemate.

A further obstacle to successful implementation of NPM reform in the hospital is the lingering prevalence of bureaucratic practices. There is an attempt in public sector organisations to construct local hierarchies in the name of improved financial control and service delivery (Brunsson & Sahlin-Andersson, 2000). There is evidence of an attempt in this hospital to do this. However, the organization is still caught in the constraints of tradition and bureaucratic practices. The future and transformation of public organizations depends on their ability to move beyond the constraints of

professional tradition and bureaucratic practices (Maddock & Morgan, 1998). Yeatman (1994:291) argues that if managers are expected to be more proactive in management, this will mean “a significant loosening of control within the system and greater reliance on information giving and receiving through various forms of accountability”. There are strong links with bureaucratic practices and rigid rules in this hospital, health board and all the way to the DoH&C. A WTE (whole time staff equivalent) ceiling has been set for each hospital and this is the form of budgetary control that most staff are familiar with. This has been evident here with the attempted introduction of the clinical directorate model. The DoH&C was unwilling to sanction the posts at senior level (grade eight) to facilitate recruitment of experienced business professionals from outside the health board system. This together with the under-resourcing of the first part of new institutional arrangements to implement a clinical directorate structure is undermining the new structures. The result of the WTE ceiling is that intended clerical support for the directorate structure has not been forthcoming. Yet there are increased accountability expectations by both hospital and health board management from this currently under resourced structure.

Australia and New Zealand, two countries regarded as aggressive reformers, have shown that performance measurement is central to the reforms (Kettl, 1997). A problem with performance indicators is that they often translate demands for accountability into practices that are more suited to the needs of external monitoring agencies, rather than the information needs of customers (Miller, 1996). The DoH&C have developed a template of general performance indicators for all sections of the hospital service which includes indicators such as waiting times, number of adverse incidents and complaints. A plethora of other NPM techniques have been ignored or overlooked – cost improvement programmes, financial management information systems, delegated budgets (Pettersen, 1999), enhanced cost systems (Ferlie et al., 1996).

Berry (1989) has argued that the central role of accounting is to support accountability. Hospital management seek greater control and accountability through engagement of

“new managers” without supplying the tools for the new managers to do their job. Accounting information can provide an important and regular mechanism through which accountability can be discharged (Hyndman, Mc Killop, Ferguson, & Oyelere, 2002). A very restricted view of budgeting exists at the hospital. There is a failure to link resources consumed with the services delivered. Kettl argues that in order for reform efforts in new public sector organisations to be sustained, it requires an expanded view of budgeting, one that links allocation decisions with their results (Kettl, 1997). The focus of accounting in the hospital is still with probity, compliance and control and there is some reluctance to loosen this control on the part of the financial controller, who is concerned that dissipated management across directorates will result in a lack of control and the possibility of financial crisis for Southop. In countries where there have been radical NPM reforms they have been supported by reforms in accounting and information systems. Accountability assumes the existence of accounting and a control system to measure actual performance and compare it to standards of expected performance (Collier, 2001). Existing accounting information systems in this hospital are unable to do this.

The current attempt to instil NPM ideas and practices is doomed to fail unless the changes in institutional structures are matched by support mechanisms. Hood (1995b:96) argues that “changes in public sector management are coupled with a greater use of financial data”. This is not the case here. The format and content of financial reports remains unchanged and is directed towards satisfying the information needs of the DoH&C. Hood has observed that changes in financial data includes “budgets (which are) becoming more ‘transparent’ in accounting terms, attributing costs to outputs and measuring outputs by quantitative performance indicators” (Hood, 1996:155). In this hospital there has been a weak attempt to match activity with a historical incremental budgeting approach as part of the service planning processes. However, there is no matching of activity achieved with resources actually consumed.

This issue of trust is an increasing concern with a public sector that was once burdened with a compliance and probity mantle. Smith (1995) and Miller (1996) advance the absence of trust as an explanation for the increased formalisation of controls in the public sector. For example, a reason advanced for the proliferation of performance controls in the UK is that they are “the means by which senior officials maintain an illusion or simulation of control within a decentralised system” (Hoggett, 1996:23). Hoggett argues that the diffusion of performance management systems has clearly had the effect of reducing professional autonomy across a wide number of different sectors. Perhaps this is one fear preventing consultant hospital doctors from engaging in a ‘clinicians in management’ mode in this hospital.

Power is of concern to clinicians. A great deal of the influence of the modern professions stems from their control over the selection of new recruits, the socialization of successors, and control over conditions of incumbency (Powell & Di Maggio, 1991). They argue that skilled institution builders who gain from such a system of power will typically expend considerable effort to maintain their dominance. Clinicians in this hospital know that they have most of the batons and the battle for complete control of the bandstand has been a long one and is ongoing. Each group (clinicians and management) know that in order for a good performance there has to be agreement on sharing of that power.

10.7 Conclusion

There is an attempt to introduce NPM ideas and practices and to make those in control of resource consumption decisions more accountable. At present hospital management is using a rhetoric of NPM but failing to acknowledge NPM successes as in the case of the Director of Nursing and chief physiotherapist. The implementation of NPM ideas and techniques is not supported by robust accounting information systems. There has been limited adoption of NPM techniques such as performance indicators. A very restricted view of budgeting exists at the hospital. The clinical directorate model will prove unsuccessful without the “buy-in” of consultant hospital doctors. In order for this to

happen there needs to be a resolution of concerns over sharing power within the hospital. For this resolution to take place there needs to be a development of trust in both directions between management and clinicians. To date the literature on implementation of NPM assumes a level of trust to secure desired organisational outcomes. Hospital and health board managements and the consultant group have occupied entrenched positions vis-à-vis the number of directorates. The reality of the existing public/private mix and the entrepreneurial activity of hospital consultants in this hospital must be recognised, if not supported. This case study shows that for this organisation a development of trust and a sharing of information to help build that trust is critical to successful implementation of NPM ideas and the avoidance of impotent new organisational structures.

Whilst dialogue between hospital management and clinicians commenced in October 1998, six and a half years later not a single clinician has agreed to lead a clinical directorate.⁷⁸ Nurse managers have not been aligned with proposed directorate structures. Two business managers have been in position for almost two years, without clerical or administrative support as a result of the WTE ceiling imposed in January 2003. One of the greatest impediments to a way forward is the existing frail and fragile accounting system that is focused on satisfying the needs of the DoH&C. The under-resourced structure has little chance of succeeding. The frailties of the accounting information system militate against the durability of the new structures, which though based on the principles of NPM are not supported. This contrasts with evidence of substantial changes in the nature of financial management information systems coinciding with changes in public sector management generally (Schick, 1990). NPM initiatives in this hospital are not in their infancy. It is possible to assess progress after six and a half years. That progress has been extremely slow. There is an unwillingness and lack of incentive to improve the current financial information systems. There may also be a lack of capability at local hospital level. Yet there is a presumption in NPM reforms that there is capacity (Hood, 1995b).

⁷⁸ In part the IHCA medical insurance indemnity crisis has contributed to this position (see section 6.8)

CHAPTER 11

AN OVERVIEW OF DIVERGENCES AND COMMONALITIES

11.1 Introduction

In this study the use of accounting in implementing NPM ideas has been explored in four Irish hospitals. In developing the four hospital case studies, fifty-seven semi-structured interviews were undertaken with fifty-four staff at the hospitals, the two health boards in which the hospitals are located, and the DoH&C. The study has focused on an empirical investigation of the use of accounting in the implementation of NPM ideas in these four Irish hospitals. This research was motivated by the absence of detailed studies on the use of accounting information in healthcare management in Ireland. The need to provide a rich account of the complex relationship between organisational context and the functioning of accounting was identified. The findings have been analysed in a thorough and comprehensive manner and every effort has been made to reduce bias and increase the objectivity in the analysis of each of the case studies. In this chapter divergences (section 11.2) and commonalities and patterns (section 11.3) across the four case studies are extracted. The implications of the case study findings for the developing literature on NPM are then examined in chapter 12.

11.2 Divergences

The importance of organizational context was discussed in the research methodology chapter (chapter 5). The findings of each case study were discussed (in chapters 7-10). In each of the sites there was a difference in the ease and speed with which NPM ideas were initiated. For instance, attempts to introduce 'clinicians in management' were accepted less reluctantly in Maria Theresa and Norhop than in Ashford and Southop. Table 11.1 illustrates some of the commonalities, patterns and divergences across the case studies.

Table 11.1: Commonalities and Divergences across the Case Studies

Elements of NPM - see Table 2.1	Ashford	Maria Theresa	Norhop	Southop
Structural change to the organization	One trial directorate	Yes	No	Attempts
Clinicians in management	Yes / new	Yes	Yes	No
Visible management	Yes	Yes	Yes	Yes
Focus on stricter cost control	Yes	Yes	Yes	Yes
Explicit measurement	No	No	No	No
Regular use of service plan by staff interviewed	Limited	Yes	Yes	No
Greater accountability required	No	Yes	Yes	No
Variable funding – casemix	Yes	Yes	No	Yes
Delegated budgets	No	No	No	No
Performance indicators	Yes	Yes	Yes	Yes
Financial targets	Yes	Yes	Yes	Yes
Changes to accounting system	No	No	Some minor	No

Contextual factors together with the actions of individuals also played a role in the degree and pace of adoption of NPM ideas. It is not intended to replicate the discussion of each case here, but instead to extract the key findings and present these within their organisational context. This study supports Pollitt's (2003) observation that the success or failure of public sector reforms depends to some extent on the functional and contextual knowledge available at the implementation of reforms. There has been varying success in implementation of reforms across the hospitals. This has to do with several factors discussed in each case.

11.2.1 Ashford

There is evidence of the low priority afforded to financial management in this hospital. Evidence was provided in this case study of the frustration by all staff – clinicians, finance, nursing and allied health professional staff with the archaic financial information systems and their poor connection with hospital health service activity. There is lack of support for accounting information systems development from hospital management, health board management and the DoH&C. Whilst any initiative to develop financial management systems requires the support of the DoH&C, to provide financing for systems development, health board managers and hospital managers (both finance and general) have a role to play in advancing arguments for the urgent need for improved information systems. Currently there is a sense of powerlessness towards financial information by those who receive and likewise by those who do not receive financial information, but yet are called to account for budget overruns in the hospital. This anomalous process leads to tensions between hospital management and clinicians. Elements of new public management have arrived in this hospital via the service planning process. The intention was to link activity and resources but this has proved impossible because financial resources are allocated on an aggregate incremental historical basis with little understanding of the resources consumed by each clinical service.

On the part of the majority of staff interviewed, there is a willingness and a recognition of the importance of engaging with management in initiatives to better control and utilise resources. However, there is an unwillingness to do so given the frail accounting information system. A low priority has been given to investment in accounting skills and systems development. It is very difficult to extract cost information as the drilling down facility is weak and requires expert accounting skill, a scarce and heavily committed resource at hospital level, to do this. The inability to meet infrequent requests for detailed cost information further alienates non-financial hospital staff. Accounting and finance staff at the hospitals endeavour to meet these requests, but it is the archaic and non-responsive nature of the financial system architecture that inhibits

them in their attempts to engage and involve hospital staff in financial management of their areas.

There are concerns about organisational trust expressed by some clinicians who cannot measure the extent of, or the benefit of, involvement in management given the dearth of financial information that is available to manage. The failure to replace consultant clinical time for those who partake in joint management/clinician initiatives jars with the professional and moral concerns of some clinicians. Given the extensive waiting lists and the need for clinical services, some clinicians view time spent at management meetings as a waste of clinical resources and a shunning of their professional responsibility to the patient. This creates tensions between clinicians and management. Additional resources targeted at lost clinical time resulting from such management initiatives may alleviate some of this strain on the management/clinician relationship.

11.2.2 Maria Theresa

This case study illustrates how the invisibility of accounting information persisted even when this hospital transferred from religious to health board ownership. The shift to the public sector created increased demands for access to financial information. There was a greater distribution of financial information post health board ownership. Here too the financial systems were poorly developed and incapable of providing meaningful financial information of such quality as to facilitate decision-making. Whilst the quantity and dissemination of financial information improved post health board ownership, the value and quality of the financial information was poor for management purposes. The reason for this, just as in the other public sector hospitals, was the focus of the system on meeting the stewardship requirements of the DoH&C.

However, there was a willingness by clinicians, immediately prior to and post public sector ownership, to participate in a 'clinicians in management' initiative. There was a sense of empowerment from this participation garnered after years of an absence of information about the management of the hospital. However, there was also a sense of powerlessness given two facts: that accounting information was of poor quality and

irrelevant given that it was directed towards meeting the reporting needs of the DoH&C, and that most of the budget was committed and therefore the discretionary power of the management team was limited in this context. The current accounting system is unable to produce information to provide assurances that resources are being used efficiently and effectively, an increasing requirement that the hospital management team has to defend to health board management.

There is a unified management team at the hospital, focused on improving hospital facilities and delivering a quality hospital service. Part of the reason for the cohesiveness may be the unification of effort to address the threat of possible downgrading of its acute hospital status as recommended for smaller hospitals (those with less than seven consultants in each of three specialities) by The Hanly Report (Department of Health & Children, 2003e). Clinicians, management and staff from nursing and finance have come together in a united and cohesive manner to address the management needs of the hospital. The directorate structure in this hospital has resulted in an inter-functional focus. This differs from the very rigid focus that existed prior to implementation of the directorate model.

This former religious organisation has moved from a situation in which there was considerable organisational secrecy to an environment which expects considerable transparency of financial information. However, the public sector context does not have improved financial systems to offer this hospital, which is now part of a cluster of acute hospitals in this area health board. The reality experienced by some staff at the hospital is an increase in bureaucracy, a slowing of the hospital management decision-making process and a growing tension of seeking management solutions without good quality management tools in a resource constrained situation.

11.2.3 Norhop

There is a new management structure at the apex of Norhop in the form of the Hospital Executive Committee, since 1999. This means that there is now a link between the management team and the Medical Board, who are widely viewed as the staff

responsible for consumption of resources in this hospital. Consultant hospital doctors have moved beyond their professional boundary, but this progress has not been supported by the financial information systems. Whilst there is engagement by clinicians in this hospital, there have been no other changes in organisational structures. Paramedical services report to the hospital administrator unlike in Maria Theresa, where under the directorate model, paramedical staff are part of the medical directorate. There is an increased awareness of cost reduction and efficiency objectives, key elements of NPM, throughout the hospital. This has resulted in an ongoing active search for value for money projects by many staff: clinicians, nursing, paramedical staff, and those responsible for the hospital purchasing function. Whilst financial information is not widely distributed other than between the four staff who constitute the Hospital Executive Committee, there is an increased awareness of the need for cost efficiencies by all staff.

Whilst there is a willingness to engage with management in this hospital, the need to find increased efficiencies was fuelled by the appointment of the Hanly Group to examine medical staffing in all acute hospitals. The publication of The Hanly Report recommended the removal of acute hospital status and the delineation of the hospital as a “local hospital” (Department of Health & Children, 2003e). However, the participation of clinicians with the hospital administrator in hospital management predates the formation of the Hanly group and displayed a willingness in this, the smallest of the four case study hospitals, to engage in an initiative to seek efficiencies and improve hospital management.

Whilst the hospital accounting function is carried out by health board staff and off site, there has been some development of the hospital accounting system unlike that witnessed in the other three case study hospitals. This accounting development has led to a greater understanding of the composition of Norhop’s labour cost by health board staff. One of the VFM developments subsequently introduced, with the support of consultant hospital doctors, has been a change in the rostering arrangements of non-consultant hospital doctors which has reduced the on-call component of this core

hospital labour cost. Overall there has been a change in attitude to support NPM ideas and practices in Norhop, without the support of substantial changes in accounting information.

11.2.4 Southop

The introduction of NPM ideas in Southop is not supported. There is an increased use of NPM rhetoric but a failure to move beyond this. In Southop, there is an unwillingness on the part of clinicians to engage in a 'clinicians in management' initiative and evidence of a lack of organisational trust. One of the reasons for the failure to engage clinicians in this hospital is in part due to the over prescription on the part of management before starting with a 'clinicians in management' model. The lead clinician selected by the consultant hospital doctors to lead a clinical directorate had to be a candidate whom the CEO of the health board would view as being supportive of moving forward with 'clinicians in management' at Southop. This has been a stumbling block for clinicians who saw this as an attempt to encroach on the decision-making power of the consultant hospital doctor professional group. Yet 'clinician in management' models in other hospitals moved forward on the basis of the selection of the Medical Board.

A hospital executive group, including four clinicians, was formed in October 1998 and disbanded in October 2000 because of a failure to agree on a model to involve clinicians in hospital management. It was subsequently re-formed in January 2002 and disbanded again in July 2002 without reaching agreement on a way forward. At this date a recommendation was sent to the Medical Board for ratification on a proposed directorate structure. By April 2004, there had been no agreement on a way forward. One reason advanced by hospital consultants for not moving forward with the initiative was the failure of the Minister for Health & Children to resolve the clinical indemnity insurance issue, as a result of which doctors engaged in a work to rule by continuing with their clinical work but refused to engage in any non-clinical tasks.⁷⁹

⁷⁹ See section 6.8.

There is clear resistance to change in this hospital. There is tight control of financial information at the centre of the organisation. The degree of cohesiveness which is in evidence in both Maria Theresa and Norhop is absent here. There is a sense of confrontation and delineation on the basis of professional groupings vis-à-vis management and clinicians. Whilst nursing management are required to co-operate with new management developments, there is no requirement on the part of clinicians to co-operate, although this was a clause of the consultants contract renegotiated in 1997 (see Appendix N). Despite the non co-operation of clinicians, hospital management with the support of health board management have gone ahead and delineated four clinical directorates – medicine, surgery, theatres and laboratory – and appointed three business managers. Almost two years after appointment the lack of management support from the DoH&C, health board and hospital leaves these structures weak and impotent and directorate staff frustrated and compromised. Issues of organisational trust emerged in several interviews as a key concern of staff in this hospital for the future success of a clinical directorate management model.

The differences identified between the case studies relate to a complex context of political, historical, institutional, and contemporary forces impacting on each hospital. This study does not intend to sanitise the case studies in order to extract commonalities. Instead, persistent patterns of issues acknowledged in interviews as important to the implementation of NPM ideas have been identified across the four case studies. Unambiguous universal commonalities between the cases are identified and discussed (section 11.3).

11.3 Commonalities and Patterns

Elements of NPM, detailed in the case analysis and summaries in section 11.2 and Table 11.1, have arrived in all four hospitals driven by: the National Hospitals Accreditation Process, the accountability legislation – the HAA 1996, and the partnership process at hospital level as a result of the national partnership process and successive National

Partnership Agreements.⁸⁰ There are a number of key similarities between the cases from which conclusions and recommendations can be drawn. Cross-case comparisons are made to highlight similarities and differences in implementing NPM ideas in these four Irish hospitals. The difficulty with multiple case analysis is that of reconciling that which is particular to the case with the universal. This tension exists because of the need to reconcile an individual case's uniqueness with the need to recognize and comprehend common processes at work across cases (Silverstein, 1988). A further problem of multiple case analysis is that the "cases will be analysed at high levels of inference, aggregating out the local webs of causality and ending with a smoothed set of generalizations that may not apply to any single case" (Huberman & Miles, 1994:435). The importance of context has been emphasised throughout this study. The intention in this chapter is to extract from the four case studies, each in their unique organisational context, clear evidence of important common issues surrounding implementation of NPM ideas in the four hospitals.

NPM developments in health care management in Ireland have been a response to two of the three contemporary factors identified by Yeatman (1994) as driving NPM reforms: increased social and cultural complexity and increased democratic expectations of government. Ireland has experienced rapid economic growth and success since the early 1990's fuelled in part only by the national partnership process. To cope with this economic success it has had to rely increasingly on immigrant labour which adds to the social and cultural complexity. The Irish hospital system underwent substantial spending cuts in the 1980's as public sector spending was cut. Since then there has been a capacity deficit to meet a growing demand for health care from an aging population in an increasingly affluent society. These growing expectations have been made public in the general election of 2002 when 6 health candidates were elected as independent candidates thus weakening the two large political parties and leading to the fragmentation of government. Greater awareness of the availability of new medical

Partnership Agreements (1987-2005) in Irish Hospitals: A Case Study in NPM Implementation

⁸⁰ See Table 6.4 for a list of the six National Partnership Agreements 1987 – 2005.

technologies has also increased public expectations from government and health service organisations.

The findings in the case study chapters show that in the four hospitals examined, the demands for greater control and accountability (key elements of NPM) have increased but the accounting systems have not advanced to provide information to allow managers to effect the control demanded by elected politicians. The enactment of the HAA 1996 required health boards and service providers to establish a link between the budget provided and services to be delivered. Since the enactment of this legislation, which staff in interviews frequently referred to as “the accountability legislation”, there is an expectation of greater controllability which cannot be delivered on, as the hospitals’ management control systems are only partly developed and poorly supported by useful financial information. Accounting is confined to stewardship and financial reporting purposes in each of the case study hospitals. This differs from the findings in other countries where NPM reform has meant that senior management are expected to attain control of their organisations with the help of management accounting techniques (Brunsson & Sahlin-Andersson, 2000). The use of accounting information was “a central element” in NPM reforms of Norwegian hospitals (Nyland & Pettersen, 2004:77). There has been a failure in the Irish context to understand the importance of this connection between improved management and the need for relevant accounting information. What is needed is for management accounting to realign with managerial work (Jonsson, 1998). Demands for greater accountability must be supported, as accountability depends on relevant information (Nyland & Pettersen, 2004).

The reorganising of the reporting and accounting approaches which Dunleavy and Hood (1994) noted accompanied the reorganising of management of public sector bodies elsewhere was missing in attempts to reorganise hospital management in these four hospitals. However, the lack of investment in the “accounting craft”⁸¹ in Irish hospitals is not unique. Hopwood (1990) noted that hospitals commonly guided by non-economic

⁸¹ Hopwood's phrase (1990:16).

values have not historically devoted substantial resources to the development of accounting systems. Yet management control depends on management accounting which in turn relies on the process of generating feedback information (Otley et al., 1995).

Each of the hospitals' accounting systems is tied historically to concerns for stewardship that permeated both the private and public sectors in the 1970's. Whilst private sector accounting practices have developed to reflect new modes of managing, accounting practices in the health boards and hospitals have undergone little change. The accounting systems do not match the internal processes or structures of the hospital organisations. Yet the budgetary system in each hospital has an outward appearance of rationality. But this is simply a facade. Otley (2003) noted in previous studies of accounting that in such instances the accounting system may cause or lead to dysfunctional behaviour. One dysfunctional aspect of the accounting systems in these hospitals is the way it is used by hospital general managers to call clinicians to heel/account for budget overruns. In several instances in the course of this study (and reported in the case study chapters 7-10) clinicians were not told what the budget was or how it related to service activity in the clinician's speciality, yet were called to account for budget overruns. This led and continues to lead to tensions and frustration on the part of clinicians.

Accounting change has not responded to increased calls for improved management of scarce resources in acute hospitals in Ireland. The present forms of accounting control do not appeal to those who are expected to use them. The accounting/finance departments of each of the hospitals are (in Norhop to a lesser extent) caught in a cycle of adherence to rule-based behaviour without developing significant changes to the accounting systems. The result is a set of stable routines, practiced on an annual and monthly basis with little change. The majority of staff in the hospitals' accounting departments are concerned with processing invoices and payroll. A health board accountant notes the preoccupation with ensuring "that we only make payments that we

are supposed to make". This statement is indicative of the level of financial and management information systems development in all four hospitals (with Norhop slightly better developed).

Ballantine, Brignall, & Modell (1998) argue that improvement in performance for service providers such as hospitals relies in large part on the information systems catering for the information needs of a variety of groups charged with increased control of service provision. They argue that the success of performance measurement systems in health care organisations depends greatly on the information system infrastructure and the degree of integration between information systems at various levels. In these hospitals, not only is the integration missing, but the information produced by the human resource management and separate payroll systems about its key resource – staff – conflicts, leaving large hospitals reduced to manual counting and reconciliation of staff numbers on a weekly basis for staff payment purposes. The information provided by the hospitals' accounting department was in all four cases considered irrelevant and not useful by clinical, paramedical, nursing and hospital management staff. The poor quality of the information was also recognised at health board level and by senior staff at the Department. Yet there was a sense of powerlessness concerning how the financial systems might be changed.

Financial information systems have not been seen as a priority by the Department or health board. Non-accounting hospital staff have commented for years to staff in each of the hospitals' accounting functions about the inadequacy of the information. The failure to invest in and develop financial systems is due to a number of factors: the composition of health board membership and the presence of political representation; the years of financial stringency in the 1980's (discussed in chapter 6); the poor emphasis on staff development which has failed to support the management development of staff; the restrictive personnel policies whereby staff with little aptitude for accounting and finance are promoted into the accounting and finance department; lack of political leadership at national level to address the problem; lack of commitment

and failure by staff at the DoH&C to persuade the Minister for Health and Children of the need to invest in financial management information systems to manage health expenditure. All of these factors have contributed to the present archaic financial information systems that are the primary financial resource management tool of hospitals, health board management and DoH&C.

Because of an absence of a central unit concerned with facilitating better management of resources, and because of lack of resources at local hospital level, hospital financial information systems have changed little in the years since the health boards were established after the passing of the Health Act 1970. Budgets are used as a system of expenditure accounting. Because of the absence of a link between detailed costing of activity and the approved budget in the annual Letter of Determination, budgets are not a useful management tool. This is in line with the findings of previous studies (Jones & Dewing, 1997; Lapsley, 1997; Pettersen, 2001). The exception might be Norhop where the accounting function is the responsibility of the health board, but is located away from Board headquarters in the town where the hospital is located. In this case there has been greater cognisance taken of the need for improved management information at health board level and there is a better understanding of the link between costs and activity by health board staff responsible for financial reporting at Norhop. Parker's (1986) criticism of accounting models for offering only a limited reflection of management modes of control is applicable in the case of the accounting system in each of these hospitals. Accounting is clearly disconnected from the context in which it operates.

There has always been a strict focus on the distinction between pay and non-pay expenditure in both hospital and health board financial reports. Expenditure on hospital pay is reported under seven categories, whilst hospital non-pay expenditure is reported under thirty-four categories. However, since the introduction of the highly restrictive bureaucratic form of control – the capping of staff numbers via the WTE control introduced by the DoH&C, but driven by the Department of Finance, from January 2003

– there has been some blurring of the distinction between pay and non-pay expenditure in the hospitals. Hood (1995b) noted when outlining his seven NPM doctrinal components that a greater emphasis on output control may involve a blurring of funds for pay and non-pay. In the Irish hospital context, non-pay budgets have effectively been used to circumvent the WTE control and allow hospital management to contract pay elements of support services from the non-pay budget; examples include cleaning services, laundry services, nursing support to accommodate parental/maternity leave, and certain paramedical services. Health board management interviewed in this study are aware of the dangers inherent in this approach, as pay awards and benchmarking, features of the national partnership process, do not provide for pay costs which are disguised as non-pay costs and which are hidden in the non-pay expenditure reports returned by the Boards to the DoH&C. Future financial allocations for the hospitals are likely to underestimate the pay resources required given that pay costs are disguised under non-pay headings. For example, adjustments to the minimum wage will be provided for in future budget allocations for pay resources, but will not be provided for the pay element of support services such as cleaning and laundry services disguised as non-pay costs.

In 2001, in the spirit of NPM, the Department introduced a new system of devolved control over staff numbers employed in the health service. The new system

delegated authority to the ten health boards and other health agencies to fill non-consultant posts on the basis of the resource needs indicated by their service plans. It was intended to encourage agencies to plan and manage their staff requirements on a more autonomous basis, while having regard to the availability of resources.

Comptroller and Auditor General (2004:33)

However, this flexibility was withdrawn in December 2002 and the WTE capping introduced from January 2003. In June 2003 there was an excess of 607 WTE staff in the wider health service.⁸² Despite this WTE overrun, all health boards, with the exception of the ERHA⁸³, achieved a break-even position in their financial outturns for

⁸² This figure included 360 WTE staff in the nursing area.

⁸³ The three area health boards in the ERHA region are: the Northern, East Coast and South Western Area Health Boards. They are responsible for the provision of health and personal social services to the 1.4

2001 and 2002 (Comptroller and Auditor General, 2004:34). The Health Sector Audit Report of the Comptroller and Auditor General, 2004 notes that the financial pressures experienced by the ERHA “arose from factors unrelated to approved employment levels” such as medical inflation and high-tech drugs.⁸⁴

The original change in staffing policy, introduced in January 2001, was designed to facilitate flexibility in addressing staffing needs required by each health board in their service plan. The majority of the Boards complied and achieved a break-even financial position as required by the HAA, 1996. Yet the DoH&C reasserted its bureaucratic control by unilateral imposition of WTE capping control across all health boards from January 2003. Part of the reason for the breach of the WTE ceiling by the health boards, as measured at June 2003, was a decision by the boards to replace the more expensive agency nurses with permanent staff (Comptroller and Auditor General, 2004). This decision resulted in a breach of the WTE ceiling, accounting for 360 of the 607 WTEs, but made sense in value for money terms. This is the type of decision-making encouraged by the adoption of NPM type values. Yet a success story in NPM terms, adherence to and achievement of a break-even financial position at health board level, an objective of the “accountability legislation”, was not considered a success and was followed by the introduction of a WTE ceiling for all health boards.

The responsibility of health board CEOs in respect of the budget assigned by the DoH&C was clarified by the enactment of the HAA 1996. The CEO of each area health board was now required by the HAA 1996 (section 6.2) to provide “a statement of the services to be provided by the health board and estimates of the income and expenditure of the board for the period to which the plan relates,” which “must be consistent with the financial limits” determined by the Minister for Health and Children and notified to the health board in the Letter of Determination. Since 1998 in each of the hospitals staff

million people living in Dublin, Kildare and Wicklow. They were established in March 2000, when the Eastern Health Board was dissolved. They are not part of this study.

⁸⁴ The report also noted other factors as contributing to the financial overrun outside of the area of interest of this study.

have been increasingly consulted on a departmental basis on the detail to be included in the service plan. In this way it would appear that staff have a greater role to play in the determination of their service.

However, in practice, the service planning consultation that took place was often not constructive. Many staff felt that it was token consultation only, and that core elements of their service plan were ignored and not included in the condensed overall hospital service plan and subsequent area health board service plan. The health board service plan was described as a “work of fiction” and the service planning process as “like butting your head against a brick wall” by clinicians in Ashford and Maria Theresa respectively. There was considerable evidence in the two larger case study hospitals, and to a lesser extent in the smaller hospitals, of the de-motivational outcomes of the service planning process.

There is an expectations gap, between the views of senior staff at the DoH&C and many of those directly responsible for the delivery of acute hospital services to patients, about the value of the service planning process. The output of that process – the service plan – is viewed at senior management level in the Department as one of the primary tools for managing the health service.

Service planning is a very, very serious issue in the health service generally now. Staff at Assistant Secretary level now meet the CEO of each health board and his team about three times a year.The service plan therefore has become a very obvious and highly transferred system of managing the health services..... Unless you get clinicians involved ...you are not going to get proper service planning in the acute hospital setting.

Assistant Secretary – DoH&C

One of the biggest changes has been the 1996 accountability legislation. Yes, the accountability legislation and the first charge has been the single biggest issue that has allowed budgetary management.

Assistant Principal – DoH&C

Yet the consistent majority view emerging from interviews with staff in the four hospitals is that service planning is not a valued process. Service planning represents the introduction of NPM ideas into the Irish acute hospital service via legislation, and is a significant development since 1996. However, there is a disconnection here between

the views of senior staff of the Department and those who have involved themselves in the hospitals' service planning process, over the past five years.

A second problem of the service planning process is its lack of connection with, and yet its assumed reliance on, accounting systems in the hospitals. Service planning attempts to make a connection and provide a link between hospital health service activity and assigned resources. However, the frailty of the hospital accounting systems hinders, hampers, and prevents this connection. In the four hospitals examined in this study, there is no attempt to link activity levels with financial resources either budgeted or consumed. There is no attempt because it is not possible to examine costs given the outdated nature of the accounting systems and infrastructure. Even in Norhop, where there has been an attempt to develop costing systems, there was clear evidence of staff's detachment from any financial information related to their clinical service. In the Norhop case study both the financial controller at the health board (with responsibility for Norhop's accounting function), and the health board general manager for the county of Nortville noted that: "We can't cost the service plan, because activity and finance are not related". Individual departmental service plans noted "no need to insert anything here" under the finance section. Yet this intention to connect activity levels and financial resources is at the heart of the "accountability legislation" – the HAA 1996.⁸⁵

In other public sector contexts, accounting has been considered a key element of the organisational communication system (Broadbent & Guthrie, 1992). This is not the case in these four hospitals. The service plan and the service planning process has increased the level of dialogue between departments, as support departments such as radiography and several laboratories in the hospitals attended service planning meetings of clinical departments in Ashford. In this way NPM practices are facilitating cross-departmental dialogue. Through this dialogue service needs can be increasingly understood and

⁸⁵ The service plan should include a statement of the services to be provided by the health board and estimates of the income and expenditure of the board for the period to which the plan relates.

HAA 1996, section 2(a)

prioritised. Whilst the hospital accounting system is widely acknowledged as frail, the service planning process is bringing benefits in the form of greater communication.

Hood's (2002) thermostatic vision of control requires the accounting system to generate feedback information to facilitate this form of control. The quality of the control will depend in part on the quality of the information on which it is reliant. There is limited evidence, in these four Irish hospitals, of the thermostatic vision of control over bureaucracy and public service reform envisioned by Hood (2002) and evidenced in the US, UK and New Zealand. As noted in chapter three, Hood's vision of control involved "specifying a set of desired policy outputs", making the person in charge of the public organisation responsible for delivering those outputs, and giving them some degree of decision-making autonomy for this purpose (Hood, 2002:311). The bureaucratic influence of the DoH&C as controller of the public purse was reasserted in January 2003, when it implemented a strict staff control mechanism – the WTE ceiling – for all health boards.

The difficulty with applying Hood's (2002:311) thermostatic vision of control to an analysis of these four Irish hospitals is that, whilst Hood considered it a way of "allocating risk, blame, responsibility, and reward among senior public bureaucrats and also other actors in the system", the senior staff at the DoH&C were invisible from the public eye. The accountability legislation centred on health board CEOs and on clarifying their responsibility. Yet little discretion resided at health board level. The element of discretionary funds was minimal, given that budget allocations in the Letter of Determination attached labels to new funding. Existing funding for core activity was not detailed under particular headings. Due to under-funding during the 1980's (see chapter 6), many clinical services were still poorly developed. This fact, combined with the political nature of health board composition, ensured that it was difficult to address reconfiguration of service provision at health board level. This limited the scope for

“acting creatively to deliver on the policy output settings” that had been specified.⁸⁶ As Conroy (1997:58) noted, “even with the 1996 accountability legislation, it will never be possible to have accountability ordinarily reside at health board level until authority is also seen to reside there”. What was required was a more active role for senior staff at the DoH&C to facilitate such a thermostatic model of control over public service reform. Local management of resources by hospitals was impossible without the support of financial management systems which only the DoH&C could provided the financial development support for. Neither the hospitals nor the health boards were facilitated to better manage resources, although there were repeated calls from government, via the DoH&C, for improved management. In addition there was a health management co-ordination deficit. Senior staff at the Department noted the difficulty of ten individual regional health boards and the absence of a national manager.⁸⁷

We are getting drawn in because there is no national manager. The actual management of the health service under the legislation [the Health Act, 1970] has been devolved out to the regional health boards. There is no one organisation taking overall national management responsibility. Management is not our role, but we do it.

Assistant Secretary – DoH&C

Alternative models of control have been overlooked by the Department. Strategies for achieving greater control of public sector organisations are diverse and include: pushing accountability for management of organisations further down the organisation whilst developing management practices to better monitor the decentralisation, and/or the development of comprehensive performance management information and techniques to support less involvement from the top of the organisation in the delivery of services (Hoggett, 1996). The idea of greater information flows fits well with Hood’s thermostatic vision of control which requires regular and relevant information to

⁸⁶ This phrase is from Hood (2002:312).

⁸⁷ This need for a national manager has been addressed with a significant change in structure at the apex of the Irish health system. The regional health boards have been abolished with effect from December 31st 2004 and replaced by the Health Services Executive. A consultant paediatric gastroenterologist who until his appointment worked at a Dublin hospital was approved for appointment by the Minister for Health and Children on April 12th 2005. The former CEOs of the health boards remain in place for the first six months of 2005. From July 2005 responsibilities will transfer to the new National Hospitals Office, a directorate of the Health Service Executive, who will be responsible for running all acute hospitals. Hospitals will then be managed through ten local hospital networks, corresponding to the old regional health board structures.

facilitate its working. An examination of the Integrated Management Report (supplied by the DoH&C) for 1995 and 2003 shows little difference in the layout and nature of the financial information reported over this eight year period, a period which saw the introduction of the “accountability legislation” and greater calls for accountability for health boards and hospitals alike. A “prerequisite for delegating managerial authority is a running costs system that permits operational managers to alter the mix of staff and other inputs” (Barzelay, 2001:31). This may not always be possible in public sector organizations. The development of performance management information systems and techniques to support less involvement from the top of the organisation in the delivery of services was not forthcoming at either health board or hospital level in the four case study hospitals. With the control pressure experienced through the WTE capping (introduced in January 2003), the hospitals did attempt to alter the mix of pay and non-pay costs. They did this by using existing WTE numbers to launch new service developments and contracting out support services. This allowed them to continue with implementation of developments despite the WTE capping. This was not the intention of the WTE capping, which had as its focus “the non-filling of any non-essential posts” (Department of Health & Children, 2003c:9). Staff in interviews noted that there are no “non-essential posts”, as the Irish public hospital system has not reached that stage of development yet.

Whilst there were various attempts in each of the four hospitals to engage clinicians in hospital management, it is evident that accounting control systems development lagged developments in organisational structures, and have been one impediment to successful ‘clinicians in management’ initiatives. Staff, financial and non-financial, clinical and non-clinical, management and non-management, at hospital, health board and DoH&C, consistently expressed this view. Failure to involve clinicians in some hospitals, and to support clinicians who risk becoming involved in ‘clinicians in management’ initiatives in other hospitals, has led to little change in management practices, a great deal of frustration, untold amounts of rhetoric, and a creeping distrust of clinical colleagues who have become involved in such initiatives. Unrelenting demands for the greater

evaluation of the work of others is seen as a creeping distrust spreading through the public sector (Hoggett, 1996; Miller, 1996). Accounting systems and know-how are part of the structure and use of power in organisations (Baxter & Chua, 2003). In these four case study hospitals, NPM is being implemented in organizational environments where there is a need to develop organizational trust. If the persistent attempts to implement NPM ideas is perceived as Hood (1995a) argues, as a shift from high-trust to low-trust relationships in the public sector, then this together with issues of trust inherent in bringing together clinical and managerial staff highlights the urgency in finding mechanisms to develop organisational trust. The absence of organizational trust has been one of the reasons for the slow implementation of NPM ideas in some hospitals – in particular the larger two of the hospitals in this study. The “poor relationship between doctors and general managers resulting in an absence of trust” has been identified as one of the primary obstacles to the success of these initiatives (Office for Health Management, 2003:18). The slow pace of implementation of the ‘clinicians in management’ may also be attributed to lack of support from both the Department and health boards.

I think the Department should have pushed it harder, ...and I think the health boards and management also should have pushed it a lot harder. I think it's been tokenism to some extent ... You need a structure to get people involved, a common structure and to do that you have to start putting the money into information systems.

Assistant Principal – DoH&C

The present hospital consultant contract renegotiations planned to start on November 7th 2003 have not progressed because of issues of trust related to medical indemnity insurance arrangements.

There was widespread recognition of the influence of political representation on the health service management process from the Department, staff at the health boards, and clinical and non-clinical staff in the hospitals. This political influence with its insular focus and consideration of local interest was not a positive influence on managerial accountability. The establishment of the health boards in 1970 and the passing of management responsibility to each of these left the Department free to concentrate (in

theory) on health policy development and advice to the Minister. In practice the position differed as outlined below. Whilst it was initially intended that a proportion of the Boards' funding would continue to come from local rates, with a substantial portion coming from central government, the unpopular local health charge was dropped from 1973 and all funding from then on came from the central purse (Wren, 2003). The health boards had been formed with a majority of local political representation. The change to central funding from 1973 meant that they were now able to call for additional regional health service provision without having to provide the money from local sources to fund these developments. The political nature of the Boards and the reality of initially eight, later ten, regional Boards meant that management of all health services, not just hospitals, was fragmented. This lack of management at the apex of the health service left a vacuum that could not realistically be filled by the regional health boards, with their clearly local focus and limited wider concerns.

This study considers the majority local political representation at health board level an impediment to managerial accountability and a net detraction from the best use of limited financial resources. However, it may be argued that the concerns of local politicians with hospital services may aid in discharging the democratic and constitutional forms of accountability discussed in chapter 3. However, given the inequitable access to hospital services vis-à-vis private and public patients in Irish public hospitals, this reality negates this enhancement of democratic accountability argument. This inhibitor to NPM type efficiencies has been removed with the abolition of the health boards from December 2004.

Clinicians in three of the hospitals expressed a willingness to become involved in 'clinicians in management' initiatives, which this study considers a genuine expression of intent. However, there was widespread concern about the value of such involvement given the inability of hospital accounting systems to supply relevant information on the link between service levels and funding. There were also concerns about the value of participation as clinicians considered that budgetary control was still tightly held by both

the area health boards and the DoH&C. In the two smaller hospitals where there was considerable engagement of clinicians in hospital management, there was a greater understanding of the financial budgetary pressures and other variables restricting the flow of additional funds to the hospital. This willingness to become involved in hospital management differs from the findings of other studies of hospital doctors and management (Jones & Dewing, 1997). Both clinicians and management in the four hospitals recognised the frailty of the accounting systems to support such 'clinicians in management' initiatives.

On the income side there is four or five lines of an income account and on the non pay side you have a limited number of non pay headings. I think it is very, very difficult to try and manage a service with that level of information.If we had the information presented in an easier format or more easily accessible ...it obviously would make life easier and speed things up as well.

Deputy Hospital General Manager

There is a sense of powerlessness on the part of hospital management to improve the accounting information system. In this study, in the two smaller hospitals in particular, where clinicians were involved in hospital management there was a feeling of empowerment in having a voice at the management table. This contravenes the views of many non-clinicians in this study that the locus of control and power over consumption of resources rests with consultant hospital doctors. Clinicians argue that they respond to the clinical needs of patients and do not control resource consumption given that a high proportion of hospital admissions (70%-94%) are emergency admissions through the accident and emergency department of the four hospitals. The conflicting views of clinicians (the professional group), and others such as nursing (the subordinate profession – Abbott (1988)) and hospital management on the issue of who controls hospital resources needs to be addressed.

Divergences between the cases were examined and drawn out in this chapter. Cross-case comparisons were also made to highlight commonalities and widespread similarities between the four case studies. This overview of the commonalities and divergences between the case studies is used as a basis from which conclusions are drawn in the final chapter.

CHAPTER 12

CONCLUSIONS

12.1 Introduction

This research has focused on the use of accounting in supporting the implementation of NPM ideas in four acute public sector hospitals in Ireland. The decision to undertake empirical research of this issue was in recognition of the need to study accounting in its organisational context in order to improve our understanding of the role and use of accounting (Birnberg et al., 1983; Flamholtz, 1983; Hopwood, 1983; Roberts & Scapens, 1985; Hopwood & Miller, 1994; Otley, 2003; Nyland & Pettersen, 2004; Van Helden, 2005). In this final chapter, answers are provided to the three research questions used to address the research objective outlined in chapter 5. Contributions to the developing literature on NPM are then identified (section 12.3). There is a dearth of research on both the implementation of NPM ideas and practices in Ireland and the role of accounting in supporting such implementation. Ideas for future research are then presented (section 12.4).

12.2 Research Questions - Findings

The objective of this research is to document, analyse and explain the changes in accounting that have coincided with changes in management practices in four Irish hospitals. This overriding objective was subdivided into three component parts:

- 1) How or to what extent is NPM evident in these Irish hospitals?
- 2) How are NPM ideas being implemented in these Irish hospitals?
- 3) How are accounting techniques being used to support the introduction of NPM ideas in these hospitals?

Each of these research questions was addressed in the data capture, analysis, and discussion of each of the four case study hospitals in chapters 7-10. In the preceding chapter, commonalities (section 11.2) and divergences (section 11.3) between the case

studies were identified and discussed. It is now possible to address each of the three research questions and offer a detailed response to each.

12.2.1 How or to what extent is NPM evident in these Irish Hospitals?

There is evidence of elements of NPM in each of these hospitals. There are attempts to increase hands-on management, to emphasise greater discipline in resource use, to seek more service for less money, to develop measures of performance, and to disaggregate the hospitals by breaking them into more manageable units. These are all components of NPM identified by Hood (1991; 1995b). The primary mechanism for driving NPM in Ireland is legislation, the HAA 1996. Other forces that have contributed to the implementation of NPM ideas are the National Hospitals Accreditation Process and successive National Partnership Agreements. Given the relatively small population of Ireland and a widely dispersed rural population, competition between health providers is not feasible. However, competition of a non-market nature has been institutionalised between the larger acute hospitals (32 in 2004) in the form of casemix funding. This zero sum funding system (see footnote 12) rewards efficient acute hospitals with a positive casemix adjustment and penalises inefficient hospitals with a negative adjustment. This practice supports Power's (1994) observation that public accountability has been reframed in relation to concepts such as goal definition, efficient allocation of resources and financial performance. The efficient use of resources is promoted via the casemix adjustment, whilst a requirement to adhere to financial budgetary limits has been codified under the HAA 1996.

Whilst there is an increased emphasis on accountability for results, there continues to be a strong concern with accountability for service process in acute hospitals, given the mix of public and private patients within public hospitals. The bed management function is charged with managing designated beds in line with the Health (Amendment) Act, 1991. The reality of public and private hospital service provision within the same institution and the legislation which formalised and approved this division creates further

difficulties for hospital management trying to change the focus from service process to service outcomes.

There has been some limited success in these hospitals with disaggregation. In the Maria Theresa case study (chapter 8) there was disaggregation to the extent that the hospital was divided into a resources directorate, a nursing directorate and a single clinical directorate. In Norhop (chapter 9) whilst there was engagement of clinicians in a management initiative there was no attempt to disaggregate beyond this and develop a directorate model. In the larger hospitals (Ashford and Southop) it was more difficult to reach agreement on clinical directorate models. Yet the decentralisation of resources is a key element of NPM (Hood, 1991, 1995b; Hoggett, 1996; Guthrie et al., 1997; Doig & Wilson, 1998; Denhardt & Vinzant Denhardt, 2000). This aspect of NPM is absent in these hospitals. In 2001, there was a loosening of bureaucratic controls when in the spirit of NPM, the Department introduced a new system of devolved control over staff numbers employed in the health service. The new system delegated authority to the ten health boards to fill non-consultant posts on the basis of the resource needs indicated by their service plans. It was intended to encourage agencies to plan and manage their staff requirements on a more autonomous basis, while having regard to the availability of resources. However, despite seven of the ten health boards achieving a break-even financial position in 2001 and again in 2002,⁸⁸ a bureaucratic form of control, the WTE capping, was asserted from December 2002.

The customer driven focus of NPM (Barzelay & Armajani, 1992; Hood, 1995b; Thompson, 1997) has not taken hold in the acute hospital sector. Whilst the hospitals have developed charters of patient rights and mission statements that include many references to the patients, the co-existence and provision of public and private care in Irish public hospitals has made visible the inequities in access to acute hospital care for public patients. The reality that consultant hospital doctors are paid a salary for treating

⁸⁸ The 2002 financial outturn information was not available when the Department made this decision.

public patients and a fee per clinical service delivered for treating private patients militates against equity in access to and delivery of acute hospital services. Conroy (1997)⁸⁹ used the analogy of a reward system in a bar to describe the working of the public-private mix in practice: “if a publican paid her barman by the hour for covering the bar and by the drink for covering the lounge, it would be hard to get served in the bar” (Conroy, 1997:60). This difficulty in accessing service aptly describes the public patient’s predicament.

There is weak evidence of explicit measurement and quantification of results – other critical components of NPM. A concern with performance measurement emerged and endured as a feature of NPM reforms since the 1980’s (Hood, 1995b; Olson et al., 1998). Modell (2004) found evidence of a greater reliance on quantitative, primarily accounting-based indicators to facilitate control in public sector organisations. Whilst there has been little improvement in the provision of financial information by the hospitals to the health boards and the Department since the enactment of the “accountability legislation”, an examination of the Integrated Management Report (IMR) for one health board showed that there has been a significant increase in information on staff numbers which is increasingly used to control resources in the overall health sector. Non-financial information has risen in profile, with hospitals now required to report on activity on a quarterly basis as part of a review of implementation of the service plan, the key visible outcome for hospital staff of the “accountability legislation”.

Under the current DoH&C management model, the visibility of non-financial performance measures is growing. Performance measures developed centrally by the Department in consultation with users groups and service providers constitute the national performance criteria against which hospitals are required to report quarterly. The importance of financial information for hospital management is being eroded by the greater use of non-financial forms of information such as staff numbers and the greater

⁸⁹ As noted in section 6.8

visibility of activity statistics and national performance indicators of a non-accounting nature.

12.2.2 How are NPM ideas being implemented in Irish hospitals?

The HAA 1996 is focused on increasing accountability by creating a link between approved resources and levels of service planned, agreed and subsequently delivered. The changing strategies of control observed by Hoggett (1996) in the UK public sector, involving the creation of operationally decentralised units with a simultaneous increase in centralised control over strategy and policy, has not been witnessed in acute hospital management in the case study hospitals. The opportunity for the DoH&C to concentrate on strategy and policy has not been successful given the diffused management of acute hospital services across the ten regional health boards. Evidence was provided of their continuous involvement in issues of hospital management.

Whilst the PMSA 1997 codified NPM ideas in the wider Irish public sector, the enactment of legislation for the health sector preceded this. There is a contradiction in the manner in which NPM ideas are being introduced. The HAA 1996 was to be the key link connecting resources and hospital activity. Yet the link between resources and activity is not well understood and cannot be facilitated by the accounting systems in these four hospitals. The connection between finance approved and service levels is not understood or visible to anyone given the archaic nature of the financial systems. In the absence of useful financial information there has been an increased reliance on non-financial information. What has resulted is a crude form of establishment control that does not support delegation and decentralisation.

Implementation of NPM ideas is supported by the national partnership process which involves local partnership action committees. Attempts to modernise the health service outlined in Quality and Fairness – a Health Strategy for You are linked by action points at local partnership level to benchmarking awards under Sustaining Progress 2003-2005 (Irish Government, 2003). Partnership staff have assisted in the service planning

process at hospital level by facilitating service planning meetings. The partnership process assists in achieving reform at hospital level. As noted in chapter 7 the paediatric department at Ashford Regional Hospital participated in a pilot performance management project for 2004 as one of fourteen pilot sites throughout the health service. In line with the objective of the most recent national partnership agreement of “aligning the delivery of services to the preferences and requirements of service users” (Irish Government, 2003: para 23.21), the pilot project in Ashford involved the development of a feedback mechanism for children and their families to offer them an opportunity to comment on the service provided by the paediatric unit.

12.2.3 How are accounting techniques being used to support the introduction of NPM ideas in these hospitals?

There is limited use of accounting techniques to support the introduction of NPM in these hospitals. Whilst elsewhere in addition to financial management information systems and delegated budgets, NPM has included techniques like cost-improvement programmes, performance indicators, resource allocation rules, and financial targets, only a limited set of these techniques are in evidence in these acute hospitals. Performance indicators have been developed for the acute hospital programme and hospitals are required to report on them quarterly. Yet, discharge of managerial accountability by hospital general managers continues to rely on financial information given that the focus of the accountability legislation is to deliver the agreed service plan in line with the financial resources approved. This is consistent with Ezzamel and Willmott’s (1993) and Lapsley’s (1999) findings of an increasing emphasis on financial accountability as part of NPM reforms.

Financial reports showing adverse variances are used in meetings between hospital managers and clinicians. The manner of their use creates tensions as clinicians are called to account for financial overruns where they do not have knowledge of the size of the budget or its composition. These meetings add increasingly to an underlying managerial-professional tension and are not seen as productive by either the

management group or professionals. The HAA 1996 codified the requirement to deliver services within an approved financial target. However, staff interviewed throughout the study noted the preoccupation with the “within financial target” aspect of the legislation at the expense of a disregard for the level of service delivered. There is clear evidence here of an emphasis on managerial accountability.

The existence of the “first charge” has resulted in a further increase in bureaucratic practices as in one of the area health boards in this study, health board management sliced a contingency sum off the top of the allocated budget after it had been notified to the hospital in 2003. This was held as a contingency sum at health board level in the event of a financial overrun in the hospital. This was referred to in interviews as being akin to taking sweets off a child once they had been given. The health board released these monies towards the year end once it was clear that they would not be required to shore up a financial deficit. Frequently at year end, the Department released monies during the second half of the final quarter. This created a tension and frustration for both health board and hospital general managers and financial managers who consistently preached a message of cost containment to staff in the hospitals. This end of year rush of monies undermined their efforts to adhere to financial limits. This practice may be regarded as prudent financial management, when monies are held and released to meet contingencies. However, where such monies are routinely released by the Department and health boards at year end, it destabilises prudent financial management at hospital level.

The institutionalised reality of “bail out” money at year end, for five consecutive years, creates a tension for hospital financial managers and health board financial managers alike. This type of financial behaviour has been described as a ritual game (Pettersen, 1995). Hospital financial managers and general managers continue to argue for financial rectitude as they endeavour to adhere to financial targets under the HAA 1996. This type of financing is pernicious and militates against the type of flexible management promoted by NPM ideas. A further implication of this tight control of resources by the

Department from January to November and flood of money⁹⁰ in November/early December is that it militates against financial managers who have endeavoured to adhere to budgetary limits and works in favour of those who ignore adherence to the budgetary limit requirement. Those who adhere to the budgetary limit, and who are unable to spend the additional allocation by year end, achieve a positive budgetary position, which is not welcomed nor appreciated by a public who experience difficulties accessing health services. Health boards who have a positive year-end net financial position receive adverse press coverage on publication of their annual report.

One positive use of accounting is its use in the casemix funding allocation where those hospitals considered as efficient are rewarded by a positive casemix adjustment. The information for casemix is captured by the HIPE⁹¹ department in hospitals which work independently of the accounting and finance function under the direction of the HIPE co-ordinator. The role of casemix is increasing. In the 2005 allocation it accounted for twenty per cent of the variable portion of hospital in-patient and day-case funding, having risen from twenty percent for in-patient and fifteen per cent for day-case funding in 2004. There are plans to increase both of these percentages to fifty percent by 2008.⁹²

12.3 Implications for the Developing NPM Literature

Whilst the reform model in Ireland endeavoured to promote accountability, it did not coincide with greater managerial autonomy at hospital level. There was little sign, in these hospitals, of the more active control of public sector organisations by managers wielding discretionary power as envisioned by Hood (1995b:97). Autonomy was restricted at Department level and was further dissipated at health board level due to the political nature of boards and the existence of a majority of political representation. The implementation of a strong form of bureaucratic control from January 2003 with the WTE capping on staff in the hospitals exerted the bureaucratic authority of the DoH&C. At the beginning of this study the importance of context was argued. The political

⁹⁰ So described in several interviews.

⁹¹ Hospital In-Patient Enquiry

⁹² As discussed, in April 2005, with Department of Health & Children staff with responsibility for HIPE.

context, just like the religious context, has influenced the shape and arrangement of the current public hospital service. The principal Irish political parties emerged in the struggle for Independence (won in 1922) and the subsequent civil war over the terms of that Independence. Politics in Ireland has been dominated by these two parties ever since. There has never been a strong history of social democratic politics in Ireland and a concern with free health for all.

Unlike in other European countries, where political parties emerged from class conflicts between a declining affluent class and a growing influential poor, Ireland's concerns with nationalism continued to influence the development of its political society (Wren, 2003). Fianna Fail, the present dominant political party, have ruled as a single party or as the dominant political party in coalition for 55 of the 82 years to 2004. In the late 1970's the expansionist policies of a Fianna Fail single party government saw an escalation in national debt, which lead to the retrenchment policies of the 1980's and a reduction of staff and bed numbers in Irish hospitals (see Table 6.5 for statistics on bed numbers). Reduction in staff numbers was achieved by the filling of only one in three vacancies in the health service from January 1984.⁹³ The WTE capping restriction introduced in January 2003 and applied for 2003 and 2004 is somewhat similar to the restrictive and highly bureaucratic form of control introduced in 1983. The power of the Department of Finance continued to grow during this twenty-two year period since 1983, in part due to its success in the 1990's in achieving high rates of economic growth, which fuelled investment and growth in employment and facilitated growth in public expenditure in all public policy areas including health (see chapter 6). Concern with projected declining economic growth rates in 2002 caused the Department to respond with harsh forms of bureaucratic control, in view of expanding staff numbers, despite all non ERHA health boards "achieving a break-even position in their financial outturns for 2001 and 2002" (Comptroller and Auditor General, 2004: 34)

⁹³ In a letter to the health boards on 15 December [1983] the Minister said that the public service embargo relating to filling only one in three vacancies would apply to the health service (Dail Eireann Debates, 1984).

In the discussion of trust in chapter 3, it was noted that a “weakening of trust in professionals whilst strengthening the hand of managers” (Hood, 1995b:98) can sometimes be observed simultaneously with the introduction of NPM ideas. There may be evidence of this in these hospitals. Irish doctors have a sizeable discretion over the conduct of their work and the use of hospital resources. There is little monitoring of the consultant hospital doctors’ time commitment to public patients, with some hospitals more effective than others in their monitoring attempts (Wren, 2003). The formalisation of controls under the mantle of NPM may be seen as a solution to the absence of trust. These increased attempts to manage their work have reciprocal trust implications for clinicians. However, there is willingness by clinicians in this study to seek greater financial information and an interest in knowing financial information about their clinical service.

As noted in the earlier discussion of trust (in chapter 3), it is a vital component of every interaction system (Blau, 1964; Simmel, 1967; Lane, 2000). Given that trust is increasingly accepted as an important element in determining organisational success (Tyler & Kramer, 1996; Sako, 2000), the introduction of structural and managerial dimensions of NPM should consider issues of trust in public sector organisations staffed by professional groups. There may be opportunities to improve public sector efficiency and effectiveness by improving levels of trust between public sector employees and senior management” (Nyhan, 2000:103; Albrecht & Travaglione, 2003:88). One way to improve organisational trust is to increase communication flows throughout the organisation. Though clinicians state their interest in receiving such information, it is not clear what the result of such provision would be until accounting systems are developed and strengthened to provide useful financial information. In the two smaller hospitals – Norhop (chapter 9) and Maria Theresa (chapter 8) – participation in weekly management meetings, even without useful financial information, has led to a greater appreciation and understanding of resource constraints and the need for management decision-making.

Within the Irish hospital context there are elements of private rather than public entrepreneurship as hospital consultants are facilitated in the private practice of medicine within the public hospitals where they work. The majority of Irish hospital doctors manage private businesses and are aware of the benefits of knowing the financial position of that work. The Health (Amendment) Act 1991 institutionalised the divide between public and private patients by designating almost all hospital beds as either public or private. Whilst the formalisation of the bed designation was an attempt to protect bed capacity for the public patient, this legislative mechanism formally institutionalised the public/private division in provision of acute hospital services. Hospital managers are required to monitor bed usage and make returns to the DoH&C under the Health (Amendment) Act 1991. In the Irish context management control is increasingly sought through codification of requirements in legislation. However, as in all relations between clinicians and managers, clinical need may overrule and may be advanced for non-adherence to the bed designation ratio.

Clinicians in this study were not unwilling to accept greater accountability for resource consumption by their clinical services. There was widespread awareness of the deficiencies of the hospitals' accounting systems. The deficiencies created blocks to the successful engagement of clinicians in management. In some cases whilst there was a willingness to engage in management and a greater appreciation of management difficulties on the part of clinicians resulting from this engagement, there continued to be blocks to communication caused by deficiencies in the financial management information systems. Clinicians in some hospitals, discouraged by the poor accounting systems infrastructure and system development, developed their own financial system to account for expenditure. These systems developments were initiated by clinical staff increasingly called to account for cost overruns but unable to defend and justify their position with the information supplied by the hospital's finance function.

NPM ideas were introduced into the health service under the HAA, 1996. The service planning process created a dialogue between hospital staff that had been absent before.

Despite the increased workload caused by participation in service planning, groups of hospital staff, in particular nurses, valued the process. They valued the opportunity to have a forum at which they could articulate and express their views on the needs of the clinical service that they were part of. Since directors of nursing in all four hospitals are responsible for in excess of forty per cent of hospital staff, their views of NPM reform fuelled by the HAA 1996 are important. As the nurses in this study held senior nursing positions they could therefore be seen as 'administrative leaders' rather than as 'experts in caring' in Blomgren's (2003) ordering of the nursing profession. The directors of nursing unanimously considered the demands to adhere to the rigid WTE capping as a strain to reconcile their role as nurses with that of managers as members of the senior hospital management teams.

As in Covaleski & Dirsmith (1986:210), there is a frustration on the part of some senior nurse managers at being "constrained from gaining access to desired and what they consider to be necessary information". In the absence of useful financial information, their control mechanism and focus was the WTE capping. Whilst they have sought and continue to seek greater financial information all directors of nursing are critical of existing financial information systems and thus the information provided by it to them. Their willingness to accept greater responsibility for resource management and budget responsibility, provided it is properly resourced and accompanied by discretion and authority, is in line with the findings of Purdy (1993). As these directors responsible for nursing staff did not receive useful budget information, an opportunity for "natural learning" such as that encountered in the Purdy (1993:295) study may have been lost. Purdy (1993:295) found that where nurses "interacted with budgets", were provided with accounting data, and appreciated the accounting data, natural learning occurred. This may be a lost opportunity in the Irish hospital context.

NPM **assumes** the existence of accounting systems support infrastructure or at a minimum a willingness to invest in such systems. Roberts and Scapens (1985) argued that investing more heavily in accounting information was one way for senior managers

managing at a distance to secure greater control over organisational activity. That investment has been missing in the Irish context. In the absence of it bureaucratic control, in form of the WTE capping and minimum management discretion at local level, have been the experience in these hospitals. Accounting was regarded as “a key element” in the NPM conception of accountability (Hood, 1995b:94). Unlike in Australia, New Zealand and the UK where substantial changes in the capacity of financial management information systems coincided with changes in public sector management (Schick, 1990), that parallel development in accounting systems was absent in these Irish acute hospitals. This study is cognisant of the need for ‘soft systems’ support in the form of engagement and willingness to support any ‘hard accounting information systems’ development. Throughout the interviews and case studies there is some evidence of a willingness to engage with financial information.

The lack of robust hospital financial information systems has undermined and impeded the introduction of NPM and created additional tensions and frustrations between management and professional staff in the hospitals. The current manner in which limited financial information is used to call clinicians to account leads to problems concerning organisational trust. The failure to communicate useful financial information routinely to those who are called to account for both their activity and the financial position of their clinical service creates tensions. Many clinicians in this study expressed an interest in knowing the financial costs of their service. The frail hospital accounting systems are undermining attempts to engage clinicians. Without access to useful financial information by clinicians it is difficult to judge whether or not clinicians would use such information to advance the cause of hospital management in conjunction with managers or whether they would use this information more selectively for their own purposes. It may be possible to examine this issue in the near future, because as noted in chapter 6, attempts to reform hospital financial and human resource management systems are underway in Ireland.⁹⁴

⁹⁴ In April 2005 the Government appointed a new Secretary General to the DoH&C, a former assistant secretary with responsibility for public expenditure in the health sector in the Department of Finance.

At present there is a gap between hospital managements' knowledge of the nature of clinical activity and the clinicians' knowledge of the financial implications of this activity. What is required is a connecting of these two sources of information to better manage hospital resources. Whether this can be done with existing structures is difficult to foresee. The role of business managers attached to directorates in possession of both data on clinical activity and financial information would facilitate greater sharing of knowledge and increased understanding of the connections between the two. Without this connection, improved management of resources is impossible. This connects with Nyland and Pettersen's (2004) study of hospital management where they note the vital importance of departmental managers in increasing the visibility of the hospital's management control systems. However the lack of support for business managers appointed two years ago to clinical directorates leaves these staff and new structures impotent and ill-equipped to drive NPM initiatives forward.

The issue of trust emerged as a difficulty and impediment in the extent of implementation of NPM ideas, practices and structures in both of the larger hospitals, though to a lesser degree in Ashford. Successful implementation of accounting controls requires the support of willing recipients (Jones & Dewing, 1997). This study argues that issues of organisational trust and mechanisms for improving trust, not least a viable and useful accounting system, should be a substantial consideration in attempts to implement NPM ideas in organisations staffed by professional groups. This study supports Pollitt's (2003) observation that the success or failure of public sector reforms depends to some extent on the functional and contextual knowledge available at the implementation of reforms. The contextual knowledge includes an understanding of the

Also in April 2005, the Minister for Health and Children approved the appointment of the new head of the Health Service Executive – a former consultant paediatrician and head of the School of Paediatrics at University College Dublin. The first National Annual Service Plan for the entire health service, prepared by the HSE, was laid before the Oireachtas (Parliament) by the Minister for Health on the 7th of April 2005 for the year ending 31st December 2005.

historical; constitutional, political, socio-economic, administrative conditions and systems. In this study the religious context was also considered important.

This study considers that attempts to implement NPM in Irish hospital management has been slightly more than the rhetoric of efficiency observed by Bardouille (2000) but has been less than a realistic attempt given the impediment of the frail accounting systems underlying attempts to install NPM firmly in this sector. Developments to human resource and financial management systems are underway in the Irish public sector which will impact on the hospitals. Kettl (1997) and Lapsley (2001a) advise that reforms require time to take hold. NPM ideas codified nine years ago in the 'accountability legislation', the HAA 1996, were a substantial change in management to what had gone before. Whether nine years after the 'accountability legislation' is allowing sufficient time before evaluating the outcome of such changes is a subjective judgement. What is certain is that without substantial changes in the relevance, timeliness and provision of financial information for decision-making, the quality of decision-making in these hospitals will continue to suffer as evidenced by the opinion of staff at various levels in the hospitals, health boards, and the Department interviewed in this study.

12.4 Future research

There is anecdotal evidence of successful implementation of NPM in some Irish hospitals. A study of the context and nature of NPM implementation and the role of accounting information systems in supporting these changes would provide additional knowledge of the issues that warrant consideration for successful implementation of NPM. Therefore an extension of the current study to include additional hospitals would be worthwhile.

New financial and human resource management systems are currently being developed to further implement NPM ideas in acute hospitals in Ireland. The question is: will these systems carry NPM ideas forward and embed them in the hospital management system?

Longitudinal studies of these hospitals would verify the entrenchment or otherwise of NPM practices. This study serves as a benchmark against which future NPM reforms, currently underway in the acute hospital sector, may be judged. Bryman (1989:242) notes that one of the merits of case study research which is based on detailed case studies is the possibility of returning to the case study site so that "it is possible to capture processes over time." Longitudinal studies of healthcare reforms have also been advocated by Pettigrew (1989) and Lapsley (2001b:88) in recognition of the need to examine the relatively large gap between "strategic intent and operational implementation in this large, complex industry". This study contributes towards remedying the dearth of research on the role of accounting in public sector management in Ireland, by examining the issues surrounding the implementation of NPM and the role and use of accounting in facilitating/impeding that implementation in these four acute public sector hospitals. As the IHCA have accepted the assurances of the Minister for Health & Children regarding the medical indemnity insurance issue, the majority of hospital consultant doctors agreed in May 2005 to end their restrictions on non-clinical work in hospitals. This might see a new energy directed at attempts to engage clinicians in management. This possible greater involvement combined with the new financial system (FISP) and the arrival of a new national manager for hospitals in the form of the NHO, one of the directorates of the new HSE, should potentially result in improved management of hospital resources. Longitudinal studies of these four hospitals would provide an understanding of the issues arising on the introduction of new financial systems in these four hospital contexts.

In other jurisdictions (for instance, in Sweden) managerial reform initiatives have caused tensions for some nurses concerned with "protecting the integrity of their caring work in organizations where increased cost consciousness and patient turnover rates had become important principles" (Blomgren, 2003:66). Senior nursing staff interviewed in all four hospitals in this study expressed a willingness to engage with NPM ideas and practices. This study did not consider whether there was any conflict for these nurses, charged with greater managerial responsibility, between increased managerial and caring responsibilities. This is an interesting question to explore in the Irish context.

Within the current study there was conflicting evidence from staff in the DoH&C, the health boards and among staff in the four hospitals concerning the value of the service planning process. Given that this is the mechanism that is intended to deliver greater accountability, an ongoing, more in-depth and extended examination of these differing opinions would be worthwhile. This study will serve as a point of reference in future studies.

In addition there is the issue of the broader public sector in Ireland. Have attempts to implement NPM in other areas of the Irish public sector encountered similar frailties in the accounting systems? Following the announcement of the Strategic Management Initiative in 1994, local government reform commenced with the government policy document *Better Local Government* in 1996 (Irish Government, 1996). This contained elements of Hood's (1991; 1995b) concept of NPM: a greater focus on customer care and quality services, the use of performance indicators, and improved financial management. Since the Public Service Management Act 1997, which assisted in facilitating change in this sector, significant reforms have been underway in local government. In 2000, *Modernising Government— the Challenge for Local Government*, set out the progress to date in modernising local government in line with the principles outlined in the SMI initiative (Department of the Environment and Local Government, 2000). A new financial management system has been installed in local authorities. A study of the use of accounting in supporting the introduction of NPM ideas in this sector of the public service may provide useful insights into implementing public sector management change in Ireland.

APPENDICES

January 2004	Management Information
February 2004	Financial Review
March 2004	Operational Review
April 2004	Quality Management
May 2004	Human Resources
June 2004	Information Systems
July 2004	Marketing Services Review
August 2004	Community Relations
September 2004	Compliance Review
October 2004	Customer Satisfaction
November 2004	Environmental Management
December 2004	Annual Report
January 2005	Strategic Planning
February 2005	Financial Review
March 2005	Operational Review
April 2005	Quality Management
May 2005	Human Resources
June 2005	Information Systems
July 2005	Marketing Services Review
August 2005	Community Relations
September 2005	Compliance Review
October 2005	Customer Satisfaction
November 2005	Environmental Management
December 2005	Annual Report

APPENDIX A
INTERVIEWS CONDUCTED AT THE FOUR CASE STUDY HOSPITALS,
TWO HEALTH BOARDS, AND THE DoH&C

**Table A1: Interviews conducted at Ashford Hospital
(see chapter 7)**

Date of Interview	Interviewee
March 2002	Financial Controller
March 2002 and 2004	Management Accountant
April 2004	Director of Nursing
April 2004	Chief Pharmacist
April 2004	Human Resources Manager
September 2004	Partnership Facilitator – Irish National Partnership Forum
September 2004	Clinical Nurse Manager
October 2004	Senior Executive Officer
June 2004	In-Patient Coordinator / Bed Manager
June 2004	Radiography Services Manager
September 2004	Consultant Hospital Doctor 1/ Clinician 1
October 2004	Consultant Hospital Doctor 2/ Clinician 2
November 2004	Consultant Hospital Doctor 3/ Clinician 3

**Table A2: Interviews conducted at Maria Theresa Hospital
(see chapter 8)**

Date of Interview	Interviewee
April 2002	Finance Manager
April 2002	Staff Officer – Resources Directorate
May 2002	General Manager
June 2002	Ex-Finance Manager (resigned 2002)
June 2002	Director of Nursing
June 2002	Staff Officer – Care directorate
August 2002	Consultant Hospital Doctor/ Clinician 1
August 2002	Consultant Hospital Doctor/ Clinician 2
October 2003	Senior Member of Religious Order
October 2003	Senior Laboratory Technologist

**Table A3: Interviews conducted with staff at the Northern Health Board (Health Board 1) with responsibility for Ashford and Maria Theresa Hospitals
(see chapters 7 and 8)**

Date of Interview	Interviewee
March 2002 and January 2005	Corporate Management Accountant
March 2002	Systems Accountant
March 2002 and December 2004	Director of Finance
December 2004	Assistant Director of Area Health Board with responsibility for acute hospitals services

**Table A4: Interviews conducted at Norhop Hospital
(see chapter 9)**

Date Of Interview	Interviewee
October 2003	Hospital Administrator
October 2003	Director of Nursing
October 2003	Consultant Hospital Doctor 1
November 2003	Consultant Hospital Doctor 2
October 2003	Senior Physiotherapist
October 2003	Financial Controller – Health Board

**Table A5: Interviews conducted with staff at Health Board 2
responsible for Norhop and Southop Hospitals
(see chapters 9 and 10)**

Date Of Interview	Interviewee
August 2002	Staff Officer – Health Board
April 2004	Assistant CEO – Area Health Board (with responsibility for Acute Hospital Services)
February 2004	General Manager for all Health Services in the County of Nortville

**Table A6: Staff interviewed at Southop Hospital
(see chapter 10)**

Date of Interview	Interviewee
August 2002	General Manager
May 2003	Deputy General Manager
March and April 2003	Director of Nursing
March 2003	Financial Controller
May 2003	Financial Accountant
April 2003	Assistant Director of Nursing (not transcribed)
February 2004	Chief Pharmacist
February 2004	Senior Physiotherapist
November 2003	Consultant Hospital Doctor 1
February 2004	Consultant Hospital Doctor 2
March 2004	Consultant Hospital Doctor 3
February 2004	Consultant Hospital Doctor 4
April 2003	Bed Manager
April 2003	Staff with responsibility for HIPE (the Hospital In-patient Enquiry System)
March 2004	Business Manager 1 – clinical directorate
March 2004	Business Manager 2 – clinical directorate

**Table A7: Department of Health & Children staff interviewed
(relevant to all case studies)**

Date of Interview	Interviewee
April 2004	Assistant Secretary, DoH&C
April 2004	Assistant Principal, DoH&C

APPENDIX B

IRISH GOVERNMENTS IN THE 1970's-1980's

Period	Government	Economic Conditions and Political Policy
1969-1973	FF	Stimulating demand to counter externally induced recession – deliberate budget deficits
1973-1977	FG/Labour Coalition	Attempt at economic retrenchment
1977-1981	FF	Policy of job creation in the public sector
June 1981-March 1982	FG/Lab Coalition	Mini budget – policy of adjustment and retrenchment
March – November 1982	FF	
November 1982 – November 1987	FG/Labour Coalition	Retrenchment – Value for money in public spending Interested in a generalized management model for the civil service White Paper on the Public Service Separate Department of Public Service 1982-1988
1987- 1989	FF	Abolished the Department of Public Service and merged its functions with those of the Department of Finance “in the interests of better coordination of pay and staffing matters with budgetary requirements and of better utilization of highly qualified staffing resources” (Dail Eireann Debates, 1987). Reorganization of government departments – focus political attention on vital sectors where wealth and employment can most readily be created: Marine, Tourism, Agriculture and Food. Set about building a national social partnership approach.

Note: FF = Fianna Fail, FG = Fine Gael, Lab = Labour

APPENDIX C

PRESENTATION OF PAPERS DURING THIS STUDY

Table C1: Papers Presented

Date	Conference, Seminar, Workshop and location	Title of Paper	Relating to:
April 2001	Irish Accounting & Finance Association Annual Conference, Waterford Institute of Technology, Ireland	Global public sector reform: is Ireland a reluctant reformer?	The institutional background – NPM in Ireland (chapter 4)
September 2001	Irish Academy of Management Annual Conference, University of Ulster, Northern Ireland	Global public sector reform: Ireland a reluctant reformer	The institutional background – NPM in Ireland (chapter 4)
September 2001	Doctoral Colloquium, Management School, University of Edinburgh Scotland	NPM in Ireland: the institutional context of NPM in Irish hospitals	The institutional background – NPM in Ireland (chapter 4)
February 2003	Management School Seminar, University of Edinburgh, Scotland	Maria Theresa Hospital: Preliminary analysis and emerging issues	Maria Theresa Hospital case study (chapter 8)
September, 2003	European Institute for Advanced Management Studies (EIASM), Fourth Third-Sector Workshop, Fribourg, Switzerland	From secretive religious organisation to transparent public sector organisation: a story of transition	Maria Theresa Hospital case study (chapter 8)
September 2003	Chartered Institute Of Management Accountants New Public Sector Workshop, Doctoral Stream, University of Edinburgh, Scotland	The use of accounting by management in an Irish hospital: contradictions and tensions	Maria Theresa Hospital case study (chapter 8)

APPENDIX C (continued)

PRESENTATION OF PAPERS DURING THIS STUDY

Table C1 (continued): Papers Presented

Date	Conference, Seminar, Workshop and location	Title of Paper	Relating to:
May 2004	Irish Accounting and Finance Association (IAFA) Annual Conference, Belfast, Northern Ireland	NPM in an Irish hospital – a story of transition	Norhop Hospital case study (chapter 9)
June 2004	Doctoral Forum, Management School, University of Edinburgh, Scotland	The use of accounting information to measure performance in the context of accountability and management control in Irish hospitals.	All case studies – emerging issues
September 2004	Irish Academy of Management Annual Conference, Dublin	How accounting is used in an Irish hospital – trust, mistrust and its consequences	Southop Hospital case study (chapter 10)
September 2004	Chartered Institute Of Management Accountants, Public Sector Management Workshop, University of Edinburgh, Scotland	NPM in an Irish hospital: Impotent new organisational structures	Southop Hospital case study (chapter 10)
October 2004	International Conference on Accounting, Auditing and Management in Public Sector Reforms - European Institute for Advanced Management Studies (EIASM), Oslo	Obstacles to the implementation of NPM in an Irish hospital	Southop Hospital case study (chapter 10)

APPENDIX D

NATIONAL LOTTERY FUNDING

A national lottery was established in Ireland in 1986 under the National Lottery Act, 1986. The lottery funds were to be used for the purposes of sport and other recreation, national culture, the arts and the health of the community (section 5). The Minister of State at the Department of Finance in a Seanad Eireann debate on the National Lottery Bill 1986 noted that “the needs of sport were very much to the forefront in the Government’s thinking when drawing up plans for the lottery” (Seanad Eireann, 1986). The lottery was a greater than anticipated success. The cash intake in 1987 of over €1 million had grown to €336 million by 1995 and to €559 million by 2003. Allocation of funds to beneficiary groups is detailed in Table D1 below.

Table D1 Allocation of National Lottery to Beneficiaries

	Total Fund for Beneficiaries	Fund allocated in each year	Allocation to Sport	Allocation to Arts, Culture & National Heritage	Allocation to Health
	€m	€m	€m	€m	€m
1990	68.58	94.36 <i>100%</i>	43.22 <i>45.8%</i>	36.14 <i>38.3%</i>	15.00 <i>15.9%</i>
1995	127.89	107.77 <i>100%</i>	34.70 <i>32.2%</i>	36.00 <i>33.4%</i>	37.07 <i>34.4%</i>
2000	162.81	169.52 <i>100%</i>	61.03 <i>36.0%</i>	34.58 <i>20.4%</i>	73.91 <i>43.6%</i>
2003	186.70	202.00 <i>100%</i>	114.74 <i>56.8%</i>	24.24 <i>12.0%</i>	63.02 <i>31.2%</i>

Source: Information supplied by the National Lottery Beneficiary Fund

Sport received a declining proportion until 2003 when this pattern was reversed. Additional monies were allocated in 2003 to the Special Olympics World Summer Games which took place in Ireland in 2003.

APPENDIX E

NORTHERN AREA HEALTH BOARD BUDGET STATISTICS (see chapter 7)

Table E1: Northern Area Health Board Budget 2002

Services	%	€ 000m
Acute Services & Primary Care	40.5	261,963
Mental Health & Services for Older People	17.6	113,703
Community Services	31.1	201,292
Central Services	10.8	69,805
Total budget	100	€ 646,763

Source: Area Health Board (2002:1)

Table E2: Northern Area Health Board Acute Services Revenue Budget Allocation 2002

Services	% allocation	€ 000
Ashford Regional Hospital	63.1	147,787
Other 3 acute hospitals in the Boards area	36.9	86,277
Total	100	234,064

Source: Area Health Board (2002:4)

APPENDIX F

NORTHERN AREA HEALTH BOARD STAFF STATISTICS (see chapter 7 and 8)

Table F1: Personnel Statistics Acute Hospitals in Area Health Board

	Total staff	Management Staff	Management staff as a % of total staff
December 2000	3,795	475	12.5%
June 2003	4,533	696	15.4%
Growth in staff numbers	19%	46.5%	

Source: ** DoH&C (2004c:20-23)
 ~ DoH&C (2001c:5-8)

APPENDIX G

THE NORTHERN AREA HEALTH BOARD FINANCE FUNCTION

The purpose of the area health board finance function is to provide high quality financial services and support to management in achieving the Board's objectives.

The key responsibilities of the Department are to:

- Provide financial support to the board, finance committee and management.
- Prepare and monitor annual revenue budget.
- Apply financial control through accounting standards, procedures and practices.
- Pay funds for payroll, superannuation, goods and services.
- Prepare the statutory annual financial statements.
- Maintain accounts, records and vouchers for audit by the Comptroller and Auditor General.
- Record and safeguard the board's assets.
- Secure the income of the board.
- Manage the board's cash flow.
- Exercise financial control of voluntary organisations.
- Manage and develop financial and costing systems.
- Promote staff development.

Source: area health board web site

APPENDIX H

SERVICE PLANNING CARE GROUP MEETINGS 2002 – ASHFORD

(see chapter 7)

(Meetings to take place no later than 31st August, 2001)

Group	Attendees	Date	Time	Venue	Feedback received
Care of the Elderly					
Plastic Surgery					
Accident & Emergency					
ENT					
Ophthalmology					
Paediatrics					
Obs/Gynae					
Orthopaedic					
Orthodontic					
Cancer Services					
Cardiovascular					
All Medicine*					
Anaest/Th/ICU					
Radiology Elmpark					
Radiology Crestwood					
Laboratory					
Maintenance					
Head of Dept					
Gen Surgery					
Urology					

Submissions to General Manager's office – required no later than 14th September, 2001

* All Medicine – includes Nephrology, Neurology, Respiratory, Rheumatology

APPENDIX I

VOLUNTARY HOSPITAL STATISTICAL INFORMATION

Table I1: Public Voluntary hospitals which existed in 1968, at the time of publication of the Fitzgerald Report, and which had greater than 100 beds

Hospital	Year founded	Beds 1968*	Beds 1983**	Ethos	Outcome / current Beds	Date of transfer/ closure
Dublin						
Sir Patrick Dun's		168	172	Protestant	Closed and services transferred to St. James (771beds)	1988
Mercers	1734	124	124	Protestant		1985
Royal City of Dublin, Baggott St.	1831	193	193	Protestant		1988
Dr. Steven's	1733	203	208	Protestant		1987
Adelaide	1839	154	180	Protestant	Closed and services transferred to Tallaght (600 beds)	1998
Meath	1753	282	267	Protestant		1998
St. Laurence's		358	382	Catholic	Closed and services transferred to Beaumont (605 beds)	1987
Jervis Street	1718	245	322	Catholic		1983
Mater	1861	433	456	Sisters of Mercy	No change in ownership (540 beds)	
St. Vincent's	1834	240	500	Sisters of Charity	No change in ownership (479 beds)	
Cork						
Mercy	1857	200	258	Sisters of Mercy	(354 beds)	
North Charitable Infirmary	1744	120	126	Catholic	Closed.	1987
South Charitable Infirmary	1861	134	134	Catholic	Amalgamated in 1988. Limited company. (255 beds)	1988
Victoria	1874	74	82			
Other						
Our Lady of Lourdes, Drogheda	1939	245	363	Medical Missionaries of Mary	Health Board Ownership, due to falling numbers of religious	1997
Portiuncula	1943	204	236	Catholic sisters	Health board ownership	2001

Source: * Consultative Council on General Hospital Services (1968:131)
 ** Department of Health (1985)

APPENDIX J

DIRECTORATE MODEL AT MARIA THERESA HOSPITAL

(see chapter 8)

General Manager		
Director of Resources	Director of Cure/ Medical Director	Director of Care
<ul style="list-style-type: none"> • Finance • Personnel • IT • Maintenance • Stores • Hospital In-Patient Enquiry System 	<ul style="list-style-type: none"> • Medical • Surgery • Obstetrics • Gynaecology • Paediatrics • Anaesthetics • Radiology • Pathology <p><u>Para Medical</u></p> <ul style="list-style-type: none"> • Physiotherapy • Pharmacy • Dietetics 	<ul style="list-style-type: none"> • Nursing • Ward attendants • Catering • Social Worker • Pastoral Care • Household • Porters • School

APPENDIX K

ANNUAL SERVICE PLAN 2005

ACUTE SERVICES – PERFORMANCE INDICATORS

Performance Indicator Reference	What is being measured
AS 1	Waiting times for inpatient services
AS 2	Waiting times for outpatient services
AS 3	Monitoring of the Patient Charter in terms of individual appointment slots for outpatient appointments
AS 4	Patient satisfaction – outpatient services
AS 6 ⁹⁵	Efficiency of outpatient services in term of ratio of new to return patients
AS 7	Efficiency of outpatient services in terms of Did not Attend patients
AS 8	Use of acute sector beds
AS 9	Efficiency of inpatient services in terms of average lengths of stay
AS 10	A & E attendances
AS 12 ⁹⁶	Throughput/demand on orthopaedic services
AS 13	Efficiency of services in terms of day cases/inpatient procedure mix
AS 14	Discharge activity

Source: Health Service Executive (2004:130)

⁹⁵ There is no AS 5 noted on the national service plan.

⁹⁶ There is no AS 11 noted on the national service plan.

APPENDIX L

MARIA THERESA HOSPITAL

DIRECTORATE REPORTS TO MANAGEMENT TEAM – TEMPLATE

(see chapter 8)

Department	Goals / Achievements	Actions/ Issues	Proposed Solutions	Results / Developments

APPENDIX M

List of Performance Indicators in the Nortville, Soutville, Eastville Area Health Board Service Plan 2003 (omitted from Service Plan 2004) (see chapter 9)

Out- Patient Services	Efficiency Percentage of new patients seen in Out-Patient Department over the quarter: ... within 13 weeks of referral by General Practitioner ... within 26 weeks of referral by General Practitioner
	Percentage of patients seen in Out-Patient Department within 60 minutes of appointment time
In-Patient waiting Lists:	Equity /Access Success in achieving waiting times targets (< 12 months for adults) for in-patient admissions for the following target specialities – ENT, Orthopaedics, Cardiac Surgery/Cardiology, General Surgery, Gynaecology, Ophthalmology, Plastic Surgery, Urology, Vascular Surgery
	Success in achieving waiting times targets (< 6 months for children) for in-patient admission in the specialities as listed above
Use of Acute Sector Beds	Efficiency (a) Number of bed days lost and number of patients in the quarter as a result of patients under 65 years of age, assessed as clinically fit for discharge 12 or more hours ago, whose discharge was delayed
	(b) Number of bed days lost and number of patients in the quarter as a result of patients over 65 years of age, assessed as clinically fit for discharge 12 or more hours ago, whose discharge was delayed
	(c) Average length of stay (ALOS) reported by speciality
Patient Satisfaction/ Experience	Percentage of Out-Patient clinics where patients are given an individual appointment slot.
	Equity /Access Percentage of patients, by speciality, who have been seen by a Consultant at their first Out-Patient Department clinic appointment.
	Efficiency/Effectiveness (a) % of patients seen in Out-Patients Department who are new attendees (b) % of patients seen in Out-Patients Department who are return attendees (c) % of new patients booked for OPD who did not attend (DNA) % of return patients booked for OPD who did not attend (DNA)
Haemovigilance	The number of times in the last year the Hospital Transfusion Committee has convened. Source: Area Health Board (2003:33-34)

APPENDIX N

EXTRACTS FROM THE CONSULTANTS' COMMON CONTRACT

The Consultants Common Contract is in two parts: (i) the Contract and (ii) a Memorandum of Agreement.

Consultants in Management (Memorandum of Agreement – Section 6.6)

- 6.6.1 For hospitals to operate in an efficient and effective manner it is necessary that decisions affecting patient care are taken as near as possible to the point of service delivery. Consultants need to be involved in the management process. This involvement commences with the consultant's responsibility to manage his/her own practice and will involve co-operation with colleagues and other health professionals, at department, unit, hospital or hospital group level, extending to involvement in the management of the hospital/hospital grouping through direct membership or representation on the Hospital Executive Management board.
- 6.6.2 Each hospital or hospital grouping will have an Executive Management Board, the precise constitution and role of which will depend on the structure and size of the hospital or hospital grouping. It is equally necessary that sub-board structures are put in place to assist in the management process. The recent experience of the pilot projects in a number of hospitals confirms that the concept of a distinct unit, grouping the clinical functions together under the leadership of selected consultants (e.g. a Clinical Directorate Model), represents an effective model to facilitate the participation of hospital consultants in the management process.
- 6.6.3 It is acknowledged that the effectiveness of the leader of the unit is dependent not alone upon the calibre of the person appointed but upon the support, co-operation, and commitment of the members of the unit and of the consultants in general. The leader of the unit will be appointed by management on the recommendation of the consultants in the unit and should be for a fixed term (e.g. 3 to 5 years) and involve the allocation of a number of designated sessions to fulfil his role.

ACTS OF THE OIREACHTAS REFERRED TO IN THIS STUDY

Censorship of Publications Act, 1929

Committees of the Houses of the Oireachtas (Compellability, Privileges and Immunities of Witnesses) Act, 1997

Comptroller and Auditor General (Amendment) Act, 1993

Criminal Law (Amendment) Act, 1935

Ethics in Public Office Act, 1995

Freedom of Information Act, 1997

Health Act, 1953

Health Act, 1970

Health (Amendment) Act, 1991

Health (Amendment) (No.3) Act, 1996 (HAA 1996)

Health (Corporate Bodies) Act, 1961

Health (Family Planning) Act, 1979

Health (Family Planning) (Amendment) Act, 1993

Health Insurance Act, 1994

Health Services (Financial Provisions) Act, 1947

Ministers and Secretaries Act, 1924

National Lottery Act, 1986

Ombudsman Act, 1980

Public Charitable Hospitals (Temporary Provisions) Act, 1930

Public Charitable Hospitals (Amendment) Act, 1931

Public Charitable Hospitals Act, 1933

Public Service Management Act, 1997 (PMSA 1997)

Voluntary Health Insurance Act, 1957

Bibliography

- Abbott, A. (1988), *The System of Professions: An Essay on the Division of Expert Labour* (University of Chicago Press, London).
- Abernethy, M., W.F. Chua, P.F. Lockett and F.H. Selto (1999), Research in Managerial Accounting: Learning from Others' Experiences, *Accounting and Finance*, Vol. 39, No. 1, pp. 1-27.
- Abernethy, M. and A.M. Lillis (2001), Interdependencies in Organization Design: A Test in Hospitals, *Journal of Management Accounting Research*, Vol. 13, pp. 107-129.
- Abernethy, M. and J.U. Stoelwinder (1990), Physicians and Resource Management in Hospitals: An Empirical Investigation, *Financial Accountability & Management*, Vol. 6, No. 1, pp. 17-32.
- (1991), Budget Use, Task Uncertainty, System Goal Orientation and Subunit Performance: A Test of the "Fit" Hypothesis in Not-for-Profit Hospitals, *Accounting, Organizations & Society*, Vol. 16, No. 2, pp. 105-120.
- (1995), The Role of Professional Control in the Management of Complex Organizations, *Accounting, Organizations and Society*, Vol. 20, No. 1, pp. 1-17.
- Adnum, D. (1993), Using Performance Indicators for Effective Public Sector Management, *Management Accounting*, Vol. 4, No. 1, pp. 48-52.
- Agranoff, R. and B.A. Radin (1991), 'The Comparative Case Study Approach in Public Administration' in J. L. Perry (Ed.), *Research in Public Administration* (JAI Press, Greenwich, CT.).
- Ahrens, T. and J.F. Dent (1998), Accounting and Organizations: Realizing the Richness of Field Research, *Journal of Management Accounting Research*, Vol. 10, pp. 1-39.
- Alam, M. and S. Lawrence (1994), A New Era in Costing and Budgeting, *International Journal of Public Sector Management*, Vol. 7, No. 6, pp. 41-51.
- Albrecht, S. and A. Travaglione (2003), Trust in Public-Sector Senior Management, *International Journal of Human Resource Management*, Vol. 14, No. 1, pp. 76-92.
- An Taoiseach (1999), Launch of the Second Phase of the Strategic Management Initiative at Dublin Castle (Dublin).

- (2000), *Announcement of Performance Management and Development System: Excellence through Performance* (Dublin).
- Andersson, L.M. and T.S. Bateman (1997), Cynicism in the Workplace: Some Causes and Effects, *Journal of Organizational Behaviour*, Vol. 18, No. 5, pp. 449-469.
- Anthony, R.N. (1965), *Planning and Control Systems: A Framework for Analysis* (Division of Research, Graduate School of Business, Harvard University, Boston, Massachusetts).
- Anthony, R.N. and D.W. Young (1999), *Management Control in Non-Profit Organizations* 6th ed. (Irwin/McGraw-Hill, Boston, Massachusetts).
- Area Health Board (2002), *Service Plan* (Area Health Board, Soutville).
- (2003), *Service Plan* (Area Health Board, Soutville).
- Aucoin, P. (1995), *The New Public Management: Canada in Comparative Perspective* (The Institute for Research on Public Policy (IRPP), Montreal).
- (1996), Administrative Reform in Public Management: Paradigms, Principles, Paradoxes and Pendulums, *Governance*, Vol. 3, April, pp. 115-137.
- Ballantine, J., S. Brignall and S. Modell (1998), Performance Measurement and Management in Public Health Services: A Comparison of UK and Swedish Practice, *Management Accounting Research*, Vol. 9, No.1, pp. 71-94.
- Bardouille, N.C. (2000), The Transformation of Governance Paradigms and Modalities, *Round Table*, Vol. 353, January, pp. 81-106.
- Barrington, R. (1987), *Health Medicine & Politics in Ireland 1900-1970* (Institute of Public Administration, Dublin).
- Barrington, T.J. (1980), *The Irish Administrative System* (Institute of Public Administration, Dublin).
- Barzelay, M. (2001), *The New Public Management: Improving Research and Policy Dialogue* (University of California Press, Berkeley).
- Barzelay, M. and B. Armajani (1992), *Breaking through Bureaucracy: A New Vision for Managing in Government* (University of California Press, Berkeley).

- Baxter, J. and W.F. Chua (2003), Alternative Management Accounting Research – Whence and Whither, *Accounting, Organizations and Society*, Vol. 28, No. 2/3, pp. 97-126.
- Behn, R.D. (2003), Why Measure Performance? Different Purposes Require Different Measures, *Public Administration Review*, Vol. 63, No. 5, pp. 586-606.
- Bellamy, C. and J.A. Taylor (1998), *Governing in the Information Age* (Open University Press, Milton Keynes).
- Bellone, C.J. and G.G. Frederick (1992), Reconciling Public Entrepreneurship and Democracy, *Public Administration Review*, Vol. 52, No. 2, pp. 130-134.
- Bennis, W.G. and B. Nanus (1985), *Leaders: The Strategy for Taking Charge* (Harper & Row, New York).
- Berry, T. (1989), 'Authority, Accountability and Accounting' in W. F. Chua, T. Lowe and T. Puxty (eds.), *Critical Perspectives in Management Control* (Macmillan, London).
- Birnberg, J.G., L. Turopolec and M.S. Young (1983), The Organisational Context of Accounting, *Accounting, Organizations and Society*, Vol. 8, No. 2/3, pp. 111-129.
- Blau, P.M. (1964), *Exchange and Power in Social Life* (Wiley, New York).
- Blomgren, M. (2003), Ordering a Profession: Swedish Nurses Encounter New Public Management Reforms, *Financial Accountability & Management*, Vol. 19, No. 1, pp. 45-71.
- Blunsdon, B. and K. Reed (2003), The Effects of Technical and Social Conditions on Workplace Trust, *International Journal of Human Resource Management*, Vol. 14, No. 1, pp. 12-27.
- Booth, P. (1993), Accounting in Churches: A Research Framework and Agenda, *Accounting, Auditing & Accountability Journal*, Vol. 6, No. 4, pp. 37-67.
- Borins, S. (1997), What the New Public Management Is Achieving: A Survey of Commonwealth Experience, *Advances in International Comparative Management*, Vol. 3, Supplement, pp. 49-70.
- (1998), Lessons from the New Public Management in Commonwealth Nations, *International Public Management Journal*, Vol. 1, No. 1, pp. 37-58.

- Boston, J. (2000), The Challenge of Evaluating Systematic Change: The Case of Public Management Reform, *International Public Management Journal*, Vol. 3, No. 1, pp. 23-46.
- Boston, J., J. Martin, J. Pallot and P. Walsh (1996), *Public Management: The New Zealand Model* (Oxford University Press, Oxford).
- Boyle, R. (1995), *Towards a New Public Service* (Institute of Public Administration, Dublin).
- Brennan Commission (1935), *Commission of Inquiry into the Civil Service 1932-1935* (Government Publications Office, Dublin).
- Broadbent, J. and J. Guthrie (1992), Changes in the Public Sector: A Review of Recent 'Alternative' Accounting Research, *Accounting, Auditing & Accountability Journal*, Vol. 5, No. 2, pp. 3-31.
- Brown, P. and G. Chadwick (1997), 'Management and the Health Professional' in J. Robins (Ed.), *Reflections on Health: Commemorating Fifty Years of the Department of Health 1947-1997*, pp. 189-209 (Department of Health, Dublin).
- Brunsson, N., I. Lapsley and P. Miller (1998), Editorial: Constructing Health Care Accountants: Melding Calculation and Care, *Management Accounting Research*, Vol. 9, No. 1, pp. 31-35.
- Brunsson, N. and J. Olsen (1997), *The Reforming Organization* 2nd ed. (Fagbokforlaget, Bergen).
- Brunsson, N. and K. Sahlin-Andersson (2000), Constructing Organizations: The Example of Public Sector Reform, *Organization Studies*, Vol. 21, No. 4, pp. 721-746.
- Bryman, A. (1989), *Research Methods and Organization Studies* (Unwin Hyman, London).
- Burchell, S., C. Clubb, A.G. Hopwood, J. Hughes and J. Nahapiet (1980), The Role of Accounting in Organisations and Society, *Accounting, Organizations and Society*, Vol. 5, No. 1, pp. 5-27.
- Butler, M. (2000), *Performance Measurement in the Health Sector* (Institute of Public Management - Committee for Public Management Research Discussion Paper No. 14, Dublin).
- Carnevale, D.G. and B. Wechsler (1992), Trust in the Public Sector, *Administration & Society*, Vol. 23, No. 4, pp. 471-496.

- Cavalluzzo, K., S. and C.D. Ittner (2004), Implementing Performance Measurement Innovations: Evidence from Government, *Accounting, Organizations and Society*, Vol. 29, No. 3, pp. 243-267.
- Central Statistics Office (2003), *Census 2002: Volume 1 Population Classified by Area* (Government Publications Office, Dublin).
- Chapman, R.J.K. (1975), The Irish Public Service: Change or Reform, *Administration*, Vol. 23, No. 2, pp. 126-143.
- Cheung, A.B.L. (1996), Performance Pledges - Power to the Consumer or a Quagmire in Public Service Legitimation, *International Journal of Public Administration*, Vol. 19, No. 2, pp. 233-259.
- Collier, P.M. (2001), The Power of Accounting: A Field Study of Local Financial Management in a Police Force, *Management Accounting Research*, Vol. 12, No. 4, pp. 465-487.
- Common, R. (1998), Convergence and Transfer: A Review of the Globalisation of New Public Management, *International Journal of Public Sector Management*, Vol. 11, No. 6, pp. 440-450.
- Comptroller and Auditor General (2004), *Special Report: Health Sector Audits* (Department of Health & Children, Dublin).
- Conroy, S. (1997), 'Thoughts on the Acute Hospital System' in J. Robins (Ed.), *Reflections on Health: Commemorating Fifty Years of the Department of Health 1947 - 1997*, pp. 57-63 (Department of Health, Dublin).
- Consultative Council on General Hospital Services (1968), *Outline of the Future of the Hospital System - Report of the Consultative Council on General Hospital Services: The Fitzgerald Report* (Government Publications Office, Dublin).
- Cooper, D. (1983), Tidiness, Muddle and Things: Commonalities and Divergences in Two Approaches to Management Accounting Research, *Accounting, Organizations and Society*, Vol. 8, No. 2/3, pp. 269-286.
- Coordinating Group of Government Secretaries (1996), *Delivering Better Government - Second Report to Government* (Government Publications Office, Dublin).
- Covaleski, M. and M. Aiken (1986), Accounting and Theories of Organizations: Some Preliminary Considerations, *Accounting, Organizations and Society*, Vol. 11, No. 4/5, pp. 297-319.

- Covaleski, M. and M.W. Dirsmith (1986), The Budgetary Process of Power and Politics, *Accounting, Organizations & Society*, Vol. 11, No. 3, pp. 193-214.
- (1990), Dialectic Tension, Double Reflexivity and the Everyday Accountant, *Accounting, Organizations and Society*, Vol. 15, No. 6, pp. 543-573.
- Culbert, S.A. and J.J. Mc Donough (1986), The Politics of Trust and Organizational Empowerment, *Public Administration Quarterly*, Vol. 10, No. 3, pp. 171-188.
- Dail Eireann Debates (1931), *Dail Eireann Parliamentary Debates* Vol. 38 (Dail Eireann, Dublin).
- (1945), *Dail Eireann Parliamentary Debates* Vol. 95 (Dail Eireann, Dublin).
- (1950), *Dail Eireann Parliamentary Debates* Vol. 122 (Dail Eireann, Dublin).
- (1951), *Dail Eireann Parliamentary Debates* Vol. 126 (Dail Eireann, Dublin).
- (1953), *Dail Eireann Parliamentary Debates* Vol.136 (Dail Eireann, Dublin).
- (1969), *Dail Eireann Parliamentary Debates* Vol. 242 (Dail Eireann, Dublin).
- (1973), *Dail Eireann Parliamentary Debates* Vol. 268 (Dail Eireann, Dublin).
- (1984), *Dail Eireann Parliamentary Debates* Vol. 348 (Dail Eireann, Dublin).
- (1987), *Dail Speech - Formation of Government* Vol. 371 (Dail Eireann, Dublin).
- (1996), *Dail Eireann Parliamentary Debates* Vol. 463 (Dail Eireann, Dublin).
- (2000), *Dail Eireann Parliamentary Debates* Vol. 522 (Dail Eireann, Dublin).
- Davison, J. (2004), Sacred Vestiges in Financial Reporting: Mythical Readings Guided by Mircea Eliade, *Accounting, Auditing & Accountability Journal*, Vol. 17, No. 3, pp. 476-498.
- Deloitte & Touche (2001a), *Review of Resource Allocation to Acute Hospitals in the Area Health Board* (Area Health Board, Ashville).
- (2001b), *Value for Money Audit of the Irish Health System* (Deloitte & Touche in conjunction with York Health Economics Consortium, Dublin).
- Demski, J.S. and D.E.M. Sappington (1999), Summarization with Errors: A Perspective on Empirical Investigations of Agency Relationships, *Management Accounting Research*, Vol. 10, No. pp. 21-37.

- Denhardt, R.B. and J. Vinzant Denhardt (2000), *The New Public Service: Serving Rather Than Steering*, *Public Administration Review*, Vol. 60, No. 6, pp. 549-559.
- Denzin, N.K. (1978), *The Research Act: A Theoretical Introduction to Sociological Methods* second ed. (Mc Graw-Hill, New York).
- Denzin, N.K. and Y.S. Lincoln (2000), 'Introduction: The Discipline and Practice of Qualitative Research' in N. K. Denzin and Y. S. Lincoln (eds.), *Handbook of Qualitative Research*, pp. 1-29 (Sage Publications, London).
- Department of Defence (2003), *Statement of Strategy 2003-2005* (Department of Defence, Dublin).
- Department of Finance (2002), *Management Information Framework - Report of the Working Group on Training to the Project Management Subgroup* (Department of Finance, Dublin).
- (2004), *Public Financial Procedures* (Department of Finance, Dublin).
- Department of Health (1985), *Statistical Information Relevant to the Health Services* (Government Publications Office, Dublin).
- (1986), *Health: The Wider Dimension* (Government Publications Office, Dublin).
- (1989), *Report of the Commission on Health Funding* (Government Publications Office, Dublin).
- (1994), *Health Strategy - Shaping a Healthier Future* (Government Publications Office, Dublin).
- Department of Health & Children (1998), *Strategy Statement (1998-2001) Working for Health and Well-Being* (Department of Health & Children, Dublin).
- (2000), *Health Statistics 1999* (Government Publications Office, Dublin).
- (2001a), *Health Strategy - Quality and Fairness, a Health Strategy for You* (Department of Health & Children, Dublin).
- (2001b), *Personnel Census December 2000: Agencies Run by Health Boards* (Department of Health & Children, Dublin).
- (2001c), *Personnel Census June 2000: Agencies Run by Health Boards* (Department of Health & Children, Dublin).

- (2001d), *Personnel Census June 2000: Voluntary Hospitals* (Department of Health & Children, Dublin).
- (2002), *Acute Hospital Bed Capacity - a National Review* (Department of Health & Children, Dublin).
- (2003a), *Audit of Structures and Functions in the Health System: The Prospectus Report* (Government Publications Office, Dublin).
- (2003b), *Health Statistics 2002* (Government Publications Office, Dublin).
- (2003c), Letter of Determination from the Secretary General of the Department of Health & Children to the CEO of the Area Health Board.
- (2003d), *Report of the Commission on Financial Management and Control Systems in the Health Service: The Brennan Report* (Government Publications Office, Dublin).
- (2003e), *Report of the National Task Force on Medical Staffing: The Hanly Report* (Government Publications Office, Dublin).
- (2004a), *The Health Service Reform Programme: Phase 1 Composite Report* (Department of Health & Children, Dublin).
- (2004b), *Personnel Census December 2003: Agencies Run by Health Boards* (Department of Health & Children, Dublin).
- (2004c), *Personnel Census June 2003: Agencies Run by Health Boards* (Department of Health & Children, Dublin).
- (2004d), *Summary Activity Statistics by Health Board Area and Hospital - January to December 2002 and 2003* (Department of Health & Children, Dublin).
- (2005), *Personnel Census December 2004: Agencies Run by Health Boards* (Department of Health & Children, Dublin).
- Department of Local Government and Public Health (1933), *Report 1932-33* (Government Publications Office, Dublin).
- (1936), *The Hospitals Commission: First Report* (Government Publications Office, Dublin).

- Department of the Environment and Local Government (2000), *Modernising Government: The Challenge for Local Government* (Government Publications Office, Dublin).
- Devlin, L.S.J. (1969), *Report of the Public Services Organisation Review* (Government Publications Office, Dublin).
- Dietz, G. (2004), Partnership and the Development of Trust in British Workplaces, *Human Resource Management Journal*, Vol. 14, No. 1, pp. 5-25.
- Dignan, D.J. (1945), *Social Security: Outlines of a Scheme of National Health Insurance* (The Champion Publications Ltd., Sligo).
- Doig, A. and J. Wilson (1998), What Price New Public Management?, *Political Quarterly*, Vol. 69, No. 3, pp. 267-276.
- Dooney, S. and J. O'Toole (1998), *Irish Government Today*, 2nd ed. (Gill & Macmillan, Dublin).
- Doyle, M. (2000, 6/7 Oct). *Regulatory Reform - the Story So Far*. Paper presented at the Legislative Drafting - Emerging Trends Conference, Dublin Castle.
- Duncan, J., D.L. Flesher and M.H. Stocks (1999), Internal Control Systems in US Churches: An Examination of the Effects of Church Size and Denomination on Systems of Internal Control, *Accounting, Auditing & Accountability Journal*, Vol. 12, No. 2, pp. 142-164.
- Dunleavy, P. and C. Hood (1994), From Old Public Administration to New Public Management, *Public Money & Management*, Vol. 14, No. 3, pp. 9-16.
- Dunne, J. (1989), The Politics of Institutional Reform in Ireland: Lessons of the 1982-87 Government, *Irish Political Studies*, Vol. 4, pp. 1-20.
- Durkheim, E. (1915), *The Elementary Forms of the Religious Life* (Macmillan, New York).
- Dyer, W.G. and A.L. Wilkins (1991), Better Stories, Not Better Constructs. To Generate Better Theory: A Rejoinder to Eisenhardt, *Academy of Management Review*, Vol. 16, No. 3, pp. 613-619.
- Editorial (1943), The Voluntary Hospitals and the State, *Journal of the Irish Medical Association*, Vol. 12, No. 69, p. 25.
- Eisenhardt, K.M. (1989), Building Theories from Case Study Research, *Academy of Management Review*, Vol. 14, No. 4, pp. 532-550.

- Ezzamel, M. and H. Willmott (1993), Corporate Governance and Financial Accountability: Recent Reforms in the UK Public Sector, *Accounting, Auditing & Accountability Journal*, Vol. 6, No. 3, pp. 109-132.
- Faucett, A. and B.H. Kleiner (1994), New Developments in Performance Measures of Public Programmes, *International Journal of Public Sector Management*, Vol. 7, No. 3, pp. 63-70.
- Ferlie, E., L. Ashburner, L. Fitzgerald and A. Pettigrew (1996), *The New Public Management in Action*, 1st ed. (Oxford University Press, Oxford).
- Ferreira, L.D. and K.A. Merchant (1992), Field Research in Management Accounting and Control: A Review and Evaluation, *Accounting, Auditing & Accountability Journal*, Vol. 5, No. 4, pp. 3-34.
- Ferris, J.M. and E.A. Graddy (1997), New Public Management Theory: Lessons from Institutional Economics and Government Contracting, *Advances in International Comparative Management*, Vol. 3, Supplement, pp. 89-104.
- Fine Gael (2004). *Pursuing Accountability and Value for Money in the Public Service: Speech by Michael Noonan T.D. Chairman of the Public Accounts Committee 2004*. Paper presented at the Public Affairs Ireland Conference, Dublin.
- Fine Gael, The Labour Party and Democratic Left (1994), *A Government of Renewal* (Government Publications Office, Dublin).
- Flamholtz, E.G. (1983), Accounting, Budgeting and Control Systems in Their Organisational Context: Theoretical and Empirical Perspectives, *Accounting, Organizations and Society*, Vol. 8, No. 2/3, pp. 153-169.
- Flick, U. (2002), *An Introduction to Qualitative Research: Theory, Method and Application* (Sage, London).
- Fontana, A. and J.H. Frey (1994), 'Interviewing' in N. K. Denzin and Y. S. Lincoln (eds.), *Handbook of Qualitative Research*, pp. 361-376 (Sage Publications, Thousand Oaks, California).
- Forum on Medical Manpower (2001), *Report of the Forum on Medical Manpower* (Department of Health & Children, Dublin).
- Freidson, E. (1970), *Professional Dominance: The Social Structure of Medical Care* (Atherton, New York).

- (1975), *Doctoring Together: A Study of Professional Social Control* (University of Chicago Press, Chicago, IL).
- (1986), *Professional Powers: A Study of the Institutionalization of Formal Knowledge* (The University of Chicago Press, Chicago).
- Fremantle, A. (1963), *The Papal Encyclicals in Their Historical Context* (Mentor-Omega, New York).
- Gilbert, J.A. and L.P.T. Tang (1998), An Examination of Organizational Trust Antecedents, *Public Personnel Management*, Vol. 27, No. 3, pp. 321-338.
- Glynn, J.J. (1993), *Public Sector Financial Control and Accounting*, 2nd ed. (Blackwell Business, Oxford).
- Grealy, C. (2004). *Conclusions and Recommendations of the 'Root-and-Branch' Review of the National Casemix Programme*. Paper presented at the National Casemix Working Conference, Kilkenny, Ireland.
- Guthrie, J. (Ed.) (1993), *The Australian Public Sector: Pathways to Change* (IIR Conferences, Sydney).
- Guthrie, J. and C. Humphrey (1996), Public Sector Financial Management Developments, *Research in Governmental Nonprofit Accounting*, Vol. 9, No. pp. 283-302.
- Guthrie, J., O. Olson and C. Humphrey (1997), Public Financial Management Change in OECD Nations, *Advances in International Comparative Management*, Vol. 3, Supplement, pp. 255-269.
- (1999), Debating Developments in New Public Financial Management: The Limits of Global Theorising and Some New Ways Forward, *Financial Accountability & Management*, Vol. 15, No. 3 & 4, pp. 209-228.
- Hardy, C., N. Phillips and T. Lawrence (2000), 'Distinguishing Trust and Power in Interorganizational Relations: Forms and Facades of Trust' in C. Lane and R. Bachmann (eds.), *Trust within and between Organizations: Conceptual Issues and Empirical Applications*, pp. 64-87 (Oxford University Press, New York).
- Healey, M.J. and M.B. Rawlinson (1994), 'Interviewing Techniques in Business and Management Research' in V. J. Wass and P. E. Wells (eds.), *Principles and Practice in Business and Management Research*, pp. 123-146 (Dartmouth, Aldershot).

- Health Boards Executive (2003), *Admissions and Discharge Guidelines: Health Strategy Implementation Project 2003* (Department of Health & Children, Dublin).
- Health Service Executive (2004), *Draft Service Plan 2005*.
- Hensey, B. (1988), *The Health Services of Ireland*, 4th ed. (Institute of Public Administration, Dublin).
- Hofstede, G. (1981), Management Control of Public and Not-for-Profit Activities, *Accounting, Organizations and Society*, Vol. 6, No. 3, pp. 193-211.
- Hogan, G. and G. Whyte (1994), *The Irish Constitution*, 3rd ed. (Butterworth, Dublin).
- Hoggett, P. (1996), New Modes of Control in the Public Service, *Public Administration*, Vol. 74, No. 1, pp. 9-32.
- Honohan, P. (1987), 'Macroeconomic and Fiscal Deviations from Plan 1985-1987' in *Perspectives on Economic Policy* (Centre for Policy Studies, UCD, Dublin).
- Hood, C. (1974), Administrative Disease: Some Types of Dysfunctionality in Administration, *Public Administration*, Vol. 52, No. 4, pp. 439-455.
- (1991), A Public Management for All Seasons?, *Public Administration*, Vol. 69, No. 1, Spring, pp. 3-19.
- (1994), Review of "Public Sector Management in Australia" by John Wanna, Ciaran O Faircheallaigh and Patrick Weller (Macmillan, Melbourne, 1992), *Public Administration*, Vol. 72, No. 4, Winter, pp. 618-620.
- (1995a), Emerging Issues in Public Administration, *Public Administration*, Vol. 73, No. 1, pp. 165-184.
- (1995b), The "New Public Management" in the 1980's: Variations on a Theme, *Accounting, Organizations and Society*, Vol. 20, No. 2/3, pp. 93-109.
- (1996), Beyond 'Progressivism': A New 'Global Paradigm' in Public Management?, *International Journal of Public Administration*, Vol. 19, No. 2, pp. 151-177.
- (2000), Paradoxes of Public-Sector Managerialism, Old Public Management and Public Service Bargains, *International Public Management Journal*, Vol. 3, No. 1, pp. 1-22.

- (2002), Control, Bargains, and Cheating: The Politics of Public-Service Reform, *Journal of Public Administration Research and Theory*, Vol. 12, No. 3, pp. 309-333.
- Hood, C. and M. Jackson (1994), Keys for Locks in Administrative Argument, *Administration & Society*, Vol. 25, No. 4, pp. 467-488.
- Hopper, T., D.T. Otley and R.W. Scapens (2001), British Management Accounting Research: Whence and Whither: Opinions and Recollections, *British Accounting Review*, Vol. 33, No. 3, pp. 263-291.
- Hopper, T. and A. Powell (1985), Making Sense of Research into the Organizational and Social Aspects of Management Accounting: A Review of Its Underlying Assumptions, *Journal of Management Studies*, Vol. 22, No. 5, pp. 429-465.
- Hopwood, A.G. (1983), On Trying to Study Accounting in the Contexts in Which It Operates, *Accounting, Organizations and Society*, Vol. 8, No. 2/3, pp. 287-305.
- (1987), The Archaeology of Accounting Systems, *Accounting, Organizations and Society*, Vol. 12, No. 3, pp. 207-234.
- (1990), Accounting and Organisation Change, *Accounting, Auditing & Accountability Journal*, Vol. 3, No. 1, pp. 7-17.
- (1999), Situating the Practice of Management Accounting in Its Cultural Context, *Accounting, Organizations and Society*, Vol. 24, No. 5/6, pp. 377-378.
- Hopwood, A.G. and P. Miller (1994), *Accounting as Social and Institutional Practice* (University Press, Cambridge).
- Hopwood, A.G., M. Page and S. Turley (1990), *Understanding Accounting in a Changing Environment* (Prentice Hall, Hemel Hempstead, Hertfordshire).
- Houston, M. (2002, May 25th), Who Are the "Health Independents" and What Do They Want? *The Irish Times*, p. 7.
- Huberman, A.M. and M.B. Miles (1994), 'Data Management and Analysis Methods' in N. K. Denzin and Y. S. Lincoln (eds.), *Handbook of Qualitative Research*, pp. 428-444 (Sage Publications, Thousand Oaks, California).
- Humphrey, C. (2001), Paper Prophets and the Continuing Case for Thinking, *British Accounting Review*, Vol. 33, No. 1, pp. 91-103.

- Humphrey, C., P. Miller and R.W. Scapens (1993), Accountability and Accountable Management in the U K Public Sector, *Accounting, Auditing & Accountability Journal*, Vol. 6, No. 3, pp. 7-29.
- Humphrey, C., P. Miller and H. Smith (1998), 'Financial Management in the UK Public Sector: Ambiguities, Paradoxes and Limits' in O. Olson, J. Guthrie and C. Humphrey (eds.), *Global Warning: Debating International Developments in New Public Financial Management* (Cappelen Akademisk Forlag, Oslo).
- Humphrey, C. and O. Olson (1995), 'Caught in the Act': Public Services Disappearing in the World of 'Accountable' Management?' in D. Ashton, T. Hopper and R. W. Scapens (eds.), *Issues in Management Accounting*, pp. 347-370 (Prentice Hall, Hertfordshire).
- Humphrey, C. and R.W. Scapens (1996), Methodological Themes: Theories and Case Studies of Organizational Accounting Practices: Limitation or Liberation?, *Accounting, Auditing & Accountability Journal*, Vol. 9, No. 4, pp. 86-106.
- Humphreys, P.C. (1998), *Improving Public Service Delivery*, Discussion Paper 7 (Institute of Public Administration - Committee for Public Management Research, Dublin).
- Hyndman, N. (1990), Charity Accounting - an Empirical Study of the Information Needs of UK Fund Raising Charities, *Financial Accountability & Management*, Vol. 6, No. 4, pp. 295-307.
- Hyndman, N., D. Mc Killop, C. Ferguson and P. Oyelere (2002), *Credit Unions in the UK: A Study of Their Structure, Growth and Accountability* (ACCA, London).
- Implementation Group on the Strategic Management Initiative (2001), *Third Progress Report to Government of the Implementation Group on the Strategic Management Initiative* (Department of Taoiseach, Dublin).
- International Monetary Fund (2004), *Ireland: Selected Issues* (International Monetary Fund, Washington, D.C.).
- Irish Government (1958), *White Paper on Economic Development* (Government Publications Office, Dublin).
- (1966), *White Paper: The Health Services and Their Further Development* (Government Publications Office, Dublin).
- (1981), *White Paper: A Better Way to Plan the Nation's Finances* (Government Publications Office, Dublin).

- (1984), *Building on Reality* (Government Publications Office, Dublin).
- (1985), *Serving the Country Better - a White Paper on the Public Service* (Government Publications Office, Dublin).
- (1996), *Better Local Government: A Programme for Change* (Government Publications Office, Dublin).
- (1997 - 2004), *Revised Estimates for Public Services* (Government Publications Office, Dublin).
- (2003), *Sustaining Progress: Social Partnership Agreement 2003-2005* (Government Publications Office, Dublin).
- (2004), *Revised Estimates for Public Services 2004* (Government Publications Office, Dublin).
- Irish Medical Directory (2003-2004), *The Irish Medical Directory* (Dublin).
- Jacobs, K. and S. Walker (2004), Accounting and Accountability in the Iona Community, *Accounting, Auditing & Accountability Journal*, Vol. 17, No. 3, pp. 361-382.
- Johnsen, A. (1999), Implementation Mode and Local Government Performance Measurement: A Norwegian Experience, *Financial Accountability & Management*, Vol. 15, No. 1, pp. 41-66.
- Johnson, T.H. and R.S. Kaplan (1987), *Relevance Lost: The Rise and Fall of Management Accounting* (Harvard Business School Press, Boston, MA.).
- Jones, C.S. (1999), Developing Financial Accountability in British Acute Hospitals, *Financial Accountability & Management*, Vol. 15, No. 1, pp. 1-20.
- Jones, C.S. and I.P. Dewing (1997), The Attitudes of NHS Clinicians and Medical Managers Towards Changes in Accounting Controls, *Financial Accountability & Management*, Vol. 13, No. 3, pp. 261-280.
- Jones, L.R. and F. Thompson (1999), *Public Management: Institutional Renewal for the Twenty-First Century* (JAI Press Inc, Stamford, Connecticut).
- Jones, R.A.P.M. (1992), *Public Sector Accounting*, 3rd ed. (Pitman Publishing, London).
- Jonsson, S. (1998), Relate Management Accounting Research to Managerial Work!, *Accounting, Organizations and Society*, Vol. 23, No. 4, pp. 411-434.

- Kaboolian, L. (1998), The New Public Management: Challenging the Boundaries of the Management vs. Administration Debate, *Public Administration Review*, Vol. 58, No. 3, pp. 189-195.
- Kamensky, J. (1996), Role of the "Reinventing Government" Movement in Federal Management Reform, *Public Administration Review*, Vol. 56, No. 3, pp. 247-256.
- Kane, A.J. (1996), *Irish Fiscal Policy: An Assessment of Politico-Economic Explanations* (Trinity College Dublin, Dublin).
- Kaplan, R.S. (1986), The Role for Empirical Research in Management Accounting, *Accounting, Organizations and Society*, Vol. 11, No. 4-5, pp. 429-452.
- Kettl, D.F. (1997), The Global Revolution in Public Management: Driving Themes, Missing Links, *Journal of Policy Analysis and Management*, Vol. 16, No. 3, pp. 446-454.
- Khademian, A.M. (1998), What Do We Want Public Managers to Be? Comparing Reform, *Public Administration Review*, Vol. 58, No. 3, pp. 269-274.
- Kickert, W.J.M. (1997), Public Governance in the Netherlands: An Alternative to Anglo-American 'Managerialism', *Public Administration*, Vol. 75, No. 4, pp. 731-752.
- Kimber, M. and G. Maddox (2003), The Australian Public Service under the Keating Government: A Case of Weakened Accountability?, *International Journal of Public Sector Management*, Vol. 16, No. 1, pp. 61-74.
- Kurunmaki, L. (1999), Making an Accounting Entity: The Case of the Hospital in Finnish Health Care Reforms, *European Accounting Review*, Vol. 8, No. 2, pp. 219-237.
- (2004), A Hybrid Profession - the Acquisition of Management Accounting Expertise by Medical Professionals, *Accounting, Organizations and Society*, Vol. 29, No. 3/4, pp. 327-347.
- Kurunmaki, L., I. Lapsley and K. Melia (2003), Accountingization v. Legitimation: A Comparative Study of the Use of Accounting Information in Intensive Care, *Management Accounting Research*, Vol. 14, No. 2, pp. 112-139.
- Landry, R. (1993), Administrative Reform and Political Control in Canada, *International Political Science Review*, Vol. 14, No. 4, pp. 335-349.

- Lane, C. (2000), 'Introduction: Theories and Issues in the Study of Trust' in C. Lane and R. Bachmann (eds.), *Trust within and between Organizations: Conceptual Issues and Empirical Applications*, pp. 1-30 (Oxford University Press, New York).
- Lapsley, I. (1988), Research in Public Sector Accounting : An Appraisal, *Accounting, Auditing & Accountability Journal*, Vol. 1, No. 1, pp. 21-33.
- (1992), 'Reforming Financial Controls in the NHS - or Is the NHS a 'Deviant' Organisation?' in M. Ezzamel and D. Heathfield (eds.), *Perspectives on Financial Control: Essays in Memory of Kenneth Hilton*, pp. 233-254 (Chapman and Hall, London).
- (1997), The New Public Management Diaspora: The Health Care Experience, *International Association of Management Journal*, Vol. 9, No. 2, pp. 1-14.
- (1999), Accounting and the New Public Management: Instruments of Substantive Efficiency or a Rationalising Modernity?, *Financial Accountability & Management*, Vol. 15, No. 3 & 4, pp. 201-208.
- (2001a), Accounting, Modernity and Health Care Policy, *Financial Accountability & Management*, Vol. 17, No. 4, pp. 331-350.
- (2001b), The Accounting-Clinical Interface - Implementing Budgets for Hospital Doctors, *Abacus*, Vol. 37, No. 1, pp. 79-109.
- Lapsley , I. and S. Llewellyn (1995), Real Life Constructs: The Exploration of Organizational Processes in Case Studies, *Management Accounting Research*, Vol. 6, No. 3, pp. 223-235.
- Laschinger, H.K.S., J. Finegan, J. Shamian and S. Casier (2000), Organizational Trust and Empowerment in Restructured Healthcare Settings, *Journal of Nursing Administration*, Vol. 30, No. 9, pp. 413-425.
- Laughlin, R. (1990), A Model of Financial Accountability and the Church of England, *Financial Accountability & Management*, Vol. 6, No. 2, pp. 93-114.
- Laughlin, R.C., T. Hopper and P. Miller (1989), Contextual Studies of Accounting and Auditing: An Introduction, *Accounting, Auditing & Accountability Journal*, Vol. 2, No. 2, pp. 4-6.
- Lightbody, M. (2000), Storing and Shielding: Financial Management Behaviour in a Church Organisation, *Accounting, Auditing & Accountability Journal*, Vol. 13, No. 2, pp. 156-178.

- Likierman, A. (1993), Performance Indicators: 20 Early Lessons from Managerial Use, *Public Money & Management*, Vol. 13, No. 4, pp. 15-22.
- Lillis, A.M. (1999), A Framework for the Analysis of Interview Data from Multiple Field Research Sites, *Accounting and Finance*, Vol. 39, No. 1, pp. 79-105.
- Lind, E.A. and T.R. Tyler (1988), *The Social Psychology of Procedural Justice* (Plenum Books, New York).
- Llewellyn, S. (1992), The Role of Case Study Methods in Management Accounting Research: A Comment, *British Accounting Review*, Vol. 24, No. 1, pp. 17-32.
- Lynn, L.E.J. (1998), A Critical Analysis of the New Public Management, *International Public Management Journal*, Vol. 1, No. 1, pp. 107-123.
- M.Sc. Class of Assistant Secretaries 1993/94 (1994), *Strategic Management in the Irish Civil Service: A Review Drawing on Experience in New Zealand and Australia* (Dublin).
- Macintosh, N.B. (1994), *Management Accounting and Control Systems*, 1st ed. (John Wiley & Sons, Devon).
- Maddock, S. and G. Morgan (1998), Barriers to Transformation: Beyond Bureaucracy and the Market Conditions for Collaboration in Health and Social Care, *International Journal of Public Sector Management*, Vol. 11, No. 4, pp. 234-251.
- Mahon, E. (1997), 'The Development of a Health Policy for Women' in J. Robins (Ed.), *Reflections on Health: Commemorating Fifty Years of the Department of Health 1947-1997*, pp. 77-96 (Department of Health, Dublin).
- Mayston, D.J. (1985), Non-Profit Performance Indicators in the Public Sector, *Financial Accountability & Management*, Vol. 1, No. 1, pp. 51-72.
- Miles, M.B. (1979), Qualitative Data as an Attractive Nuisance: The Problem of Analysis, *Administrative Science Quarterly*, Vol. 24, No. 4, pp. 590-601.
- Miller, P. (1992), Accounting and Objectivity: The Invention of Calculating Selves and Calculable Spaces, *Annals of Scholarship*, Vol. 9, No. 1-2, pp. 61-84.
- (1994), 'Accounting as Social and Institutional Practice: An Introduction' in A. G. Hopwood and P. Miller (eds.), *Accounting as Social and Institutional Practice* (Press Syndicate of the University of Cambridge, Cambridge).
- (1996), 'Dilemmas of Accountability: The Limits of Accounting' in P. K. S. Hirst (Ed.), *Reinventing Democracy*, pp. 57-69 (Blackwell Publishers, Oxford).

- Mintzberg, H. (1996), Managing Government Governing Management, *Harvard Business Review*, Vol. 74, No. 3, pp. 75-83.
- Modell, S. (2004), Performance Measurement Myths in the Public Sector: A Research Note, *Financial Accountability & Management*, Vol. 20, No. 1, pp. 39-57.
- Morgan, D.E. and R. Zeffane (2003), Employee Involvement, Organizational Change and Trust in Management, *International Journal of Human Resource Management*, Vol. 14, No. 1, pp. 55-75.
- Morgan, G. and L. Smircich (1980), The Case for Qualitative Research, *Academy of Management Review*, Vol. 5, No. 4, pp. 491-500.
- Mulgan, R. (1997), Contracting out and Accountability, *Australian Journal of Public Administration*, Vol. 56, No. 4, pp. 106-117.
- Mullen, P. (1985), Performance Indicators - Is Anything New?, *Hospital and Health Services Review*, Vol. 81, No. 4, pp. 165-167.
- Murphy, K. (1990), 'Proletarianization or Bureaucratization; the Fall of the Professional' in R. Torstendahl and M. Burrage (eds.), *The Formation of Professions: Knowledge, State and Strategy*, pp. 71-96 (SAGE Publications Ltd, London).
- Murray, C.H. (1982), A Working and Changeable Instrument, *Administration*, Vol. 30, No. 4, pp. 43-73.
- Murray, F. (1999), *Opening Speech by Secretary General to the Government*. Paper presented at the "Management of Government in the New Millennium", University College Cork.
- Newberry, S. and P. Barnett (2001), Negotiating the Network: The Contracting Experiences of Community Mental Health Agencies in New Zealand, *Financial Accountability & Management*, Vol. 17, No. 2, pp. 133-151.
- Nolan Committee (1995), *Standards in Public Life* (HMSO, London).
- Northern Health Board (2001), *Ceim Chun Cinn, a Step Ahead - Strategy for Acute Hospitals 2001-2006* (Northern Health Board, Ashville).
- (2002), *Revenue Budget* (Northern Health Board, Ashville).
- (2004a), *Annual Financial Statements for Year Ended 31st December 2003* (Northern Health Board, Ashville).

- (2004b), *Draft Service Plan 2005* (Northern Health Board, Ashville).
- (2004c), Letter Written by the Chief Executive Officer of the Area Health Board to the Chairman of the Health Service Executive (unpublished).
- Nyhan, R.C. (2000), Changing the Paradigm: Trust and Its Role in Public Sector Organisations, *International Journal of Human Resource Management*, Vol. 30, No. 1, pp. 87-109.
- Nyland, K. and I.J. Pettersen (2004), The Control Gap: The Role of Budgets, Accounting Information and (Non) Decisions in Hospital Settings, *Financial Accountability & Management*, Vol. 20, No. 1, pp. 77-102.
- O'Donnell, J., D. (1979), *How Ireland Is Governed* (Institute of Public Administration, Dublin).
- O'Dwyer, J. (1997), 'Strategic Planning in the Irish Health Services' in J. Robins (Ed.), *Reflections on Health: Commemorating Fifty Years of the Department of Health 1947-1997*, pp. 250-260 (Department of Health, Dublin).
- OECD (1996), *Governance in Transition* (OECD, Paris).
- Office for Health Management (1999), *Clinicians in Management: A Journey, Not a Destination* (Office for Health Management, Dublin).
- (2002), *Clinicians in Management: A Review of the Initiative & Pointers to the Way Forward*, Discussion Paper No. 3 (Office for Health Management, Dublin).
- (2003), *Clinicians in Management: A Review of Clinical Leadership*, Discussion Paper No.4 (Office for Health Management, Dublin).
- O'Loughlin, R. and A. Kelly (2004), Equity in Resource Allocation in the Irish Health Service: A Policy Delphi Study, *Health Policy*, Vol. 67, No. 3, pp. 271-280.
- Olson, O., J. Guthrie and C. Humphrey (1998), *Global Warning: Debating International Developments in New Public Financial Management* (Cappelen Akademisk Forlag, Oslo).
- Osborne, D. (2000), Lessons from Abroad, *Government Executive*, Vol. 32, No. 1, pp. 35-38.
- Osborne, D. and T. Gaebler (1992), *Reinventing Government: How the Entrepreneurial Spirit Is Transforming the Public Sector from School House to State House, City Hall to Pentagon* (Addison-Wesley, Reading, MA).

- (1993), *Reinventing Government: How the Entrepreneurial Spirit Is Transforming the Public Sector* (Plume, New York).
- O'Shea, D. (1998), 'A Particular Problem in the East ...' in A. L. Leahy and M. M. Wiley (eds.), *The Irish Health System in the 21st Century* (Oak Tree Press, Dublin).
- Otley, D. (1990), Issues in Accountability and Control: Some Observations from a Study of Colliery Accountability in the British Coal Corporation, *Management Accounting Research*, Vol. 1, pp. 101-123.
- (2001), Extending the Boundaries of Management Accounting Research: Developing Systems for Performance Management, *British Accounting Review*, Vol. 33, No. 3, pp. 243-261.
- (2003), Management Control and Performance Management: Whence and Whither?, *British Accounting Review*, Vol. 35, No. 4, pp. 309-326.
- Otley, D. and A.J. Berry (1994), Case Study Research in Management Accounting and Control, *Management Accounting Research*, Vol. 5, No.1, pp. 45-65.
- Otley, D., J. Broadbent and A. Berry (1995), Research in Management Control: An Overview of Its Development, *British Journal of Management*, Vol. 6, No. Special, pp. 31-44.
- Ouchi, W.G. (1977), The Relationship between Organisational Structure and Organisational Control, *Administrative Science Quarterly*, Vol. 22, No. 1, pp. 95-113.
- PA Consulting Group (2002), *Evaluation of the Progress of the Strategic Management Initiative / Delivering Better Government Modernization Programme* (Department of An Taoiseach, Dublin).
- Painter, M. (1990), 'Values in the History of Public Administration' in J. Power (Ed.), *Public Administration in Australia - a Watershed*, pp. 75-93 (Hale & Iremonger in association with the Royal Australian Institute of Public Administration, Sydney).
- (1998), After Managerialism - Rediscoveries and Redirection; the Case of Intergovernmental Relations, *Australian Journal of Public Administration*, Vol. 57, No. 4, pp. 44-53.
- Pallot, J. (1997), "Newer Than New" Public Management, *Advances in International Comparative Management*, Vol. 3, Supplement, pp. 125-143.

- (1998), New Public Management Reform in New Zealand: The Collective Strategy Phase, *International Public Management Journal*, Vol. 1, No. 1, pp. 1-18.
- (2003), A Wider Accountability? The Audit Office and New Zealand's Bureaucratic Revolution, *Critical Perspectives on Accounting*, Vol. 14, No. 1/2, pp. 133-156.
- Parker, D. (1999), Regulation of Privatised Public Utilities in the UK: Performance and Governance, *International Journal of Public Sector Management*, Vol. 12, No. 3, pp. 213-235.
- Parker, L.D. (1986), *Developing Control Concepts in the 20th Century* (Garland, New York).
- Parker, L.D. and J. Guthrie (1990), 'Public Sector Accounting and the Challenge of Managerialism' in J. Forster and J. Wanda (eds.), *Control and Management of Budgetary Processes*, pp. 117-129 (MacMillan, Sydney).
- Patton, M.Q. (2002), *Qualitative Research and Evaluation Methods* (Sage Publications, California).
- Pedhazur, E.J. and L. Pedhazur Schmelkin (1991), *Measurement, Design, and Analysis: An Integrated Approach* (Lawrence Erlbaum Associates, Hillsdale, New Jersey).
- Pettersen, I.J. (1995), Budgetary Control of Hospitals - Ritual Rhetorics and Rationalized Myths?, *Financial Accountability and Management*, Vol. 11, No. 3, pp. 207-221.
- (1999), Accountable Management Reforms: Why the Norwegian Hospital Reform Experiment Got Lost in Implementation, *Financial Accountability & Management*, Vol. 15, No. 3 & 4, pp. 377-396.
- (2001), Implementing Management Accounting Reforms in the Public Sector: The Difficult Journey from Intentions to Effects, *European Accounting Review*, Vol. 10, No. 3, pp. 561-581.
- Pettigrew, A. (1989), 'Longitudinal Methods to Study Change: Theory and Practice' in R. Mansfield (Ed.), *Frontiers of Management Research* (Routledge, London).
- Plowden, W. (1994), Public Interests the Public Services Serve: Efficiency and Other Values, *Australian Journal of Public Administration*, Vol. 53, No. 3, pp. 304-312.

- Podsakoff, P.M., S.B. Mackenzie and W.H. Bommer (1996), Transformational Leadership Behaviors and Substitutes for Leadership as Determinants of Employee Satisfaction, Commitment, Trust and Organizational Citizenship Behaviors, *Journal of Management*, Vol. 22, No. 2, pp. 259-299.
- Pollitt, C. (1988), *Managerialism and the Public Services* (Basil Blackwell, Oxford).
- (2003), Public Management Reform: Reliable Knowledge and International Experience, *OECD Journal on Budgeting*, Vol. 3, No. 3, pp. 121-136.
- Pollitt, C. and G. Bouckaert (2000), *Public Management Reform - a Comparative Analysis* (Oxford University Press, Oxford).
- Powell, W.W. and P.J. Di Maggio (Eds.) (1991), *The New Institutionalism in Organizational Analysis* (The University of Chicago Press, Chicago).
- Power, M. (1994), *The Audit Explosion* (Demos, London).
- Power, M. and R. Laughlin (1992), 'Critical Theory and Accounting' in N. Alvesson and H. Willmott (eds.), *Critical Management Studies*, pp. 113-135 (Sage, London).
- Purdy, D. (1993), Ward Sisters and Financial Management Accounting, *Financial Accountability & Management*, Vol. 9, No. 4, pp. 279-296.
- Report of the Tribunal of Inquiry - Dunne Payments (1997), (Government Publications Office, Dublin).
- Report of the Tribunal of Inquiry into the Beef Processing Industry (1994), (Government Publications Office, Dublin).
- Report of the Tribunal of Inquiry into the Blood Transfusion Service Board (1997), (Government Publications Office, Dublin).
- Robbins, G. and I. Lapsley (2005, forthcoming), 'NPM and the Irish Public Sector: From Reluctant Reformer to Statutory Codification' in J. Guthrie, C. Humphrey, O. Olson and L. Jones (eds.), *International Public Financial Management Reform: Progress, Contradictions and Challenges* (Information Age Press, USA).
- Roberts, J. and R.W. Scapens (1985), Accounting Systems and Systems of Accountability: Understanding Accounting Practices in Their Organisational Contexts, *Accounting, Organizations and Society*, Vol. 10, No. 4, pp. 443-456.
- Robinson, M.T.W. (1974), The Role of the Irish Parliament, *Administration*, Vol. 22, No. 1, pp. 3-25.

- Rosenbloom, D. and J. Carroll (1990), *Toward Constitutional Competence: A Casebook for Public Administrators* (Prentice-Hall, Englewood Cliffs NJ).
- Rubin, H. and I. Rubin (1995), *Qualitative Interviewing: The Art of Hearing Data* (Sage, Thousand Oaks, CA).
- Ryan, B., R.W. Scapens and M. Theobald (2000), *Research Method and Methodology in Finance and Accounting*, second ed. (Thomson, London).
- Sako, M. (2000), 'Does Trust Improve Business Performance?' in C. Lane and R. Bachmann (eds.), *Trust within and between Organizations: Conceptual Issues and Empirical Applications*, pp. 88-109 (Oxford University Press, New York).
- Saunders, M., P. Lewis and A. Thornhill (2003), *Research Methods for Business Students* (Pearson Education Limited, Harlow, Essex).
- Scapens, R.W. (1990), Researching Management Accounting Practice: The Role of Case Study Methods, *British Accounting Review*, Vol. 22, No. 3, pp. 259-282.
- Schick, A. (1990), Budgeting for Results: Recent Developments in Five Industrialized Countries, *Public Administration Review*, Vol. 50, No. 1, pp. 26-34.
- (1996), *The Spirit of Reform: Managing the New Zealand State Sector in a Time of Change* (State Services Commission and the Treasury, New Zealand).
- Seanad Eireann (1986), *Seanad Eireann Debate: National Lottery Bill - Second Stage* (Seanad Eireann, Dublin).
- Shanley, D.J. (1944), The Reorganisation of the Medical Services, *Journal of the Irish Medical Association*, Vol. 14, No. 82, pp. 40-43.
- Silverstein, A. (1988), An Aristotelian Resolution of the Ideographic Versus Nomothetic Tension, *American Psychologist*, Vol. 43, No. 6, pp. 425-430.
- Simmel (1967), *The Sociology of Georg Simmel* (Free Press, New York).
- Smith, P. (1990), The Use of Performance Indicators in the Public Sector, *Journal of the Royal Statistical Society*, Vol. 153, No. 1, pp. 53-72.
- (1995), 'Performance Indicators and Control in the Public Sector' in A. Berry, J. Broadbent and D. Otley (eds.), *Management Control - Theories, Issues and Practices* (MacMillan Press, London).

- Spicer, B.H. (1992), The Resurgence of Cost and Management Accounting: A Review of Some Recent Developments in Practice, Theories and Case Research Methods, *Management Accounting Research*, Vol. 3, No. 1, pp. 1-38.
- Stake, R.E. (1994), 'Case Studies' in N. K. Denzin and Y. S. Lincoln (eds.), *Handbook of Qualitative Research*, pp. 236-247 (Sage Publications, Thousand Oaks, California).
- Stapleton, J. (1991), Civil Service Reform: 1969-87, *Administration*, Vol. 39, No. 4, pp. 303-335.
- Stark, A. (2002), What Is New Public Management?, *Journal of Public Administration Research and Theory*, Vol. 12, No. 1, pp. 137-152.
- Stewart, J. (1993), Reinventing Accountability, *Demos Quarterly*, Winter, No. 1, pp. 14-18.
- Stoelwinder, J.U. and M. Abernethy (1989), The Design and Implementation of a Management Information System for Australian Public Hospitals, *Health Services Management Research*, Vol. 2, No. 3, pp. 176-191.
- Terry, L.D. (1993), Why We Should Abandon the Misconceived Quest to Reconcile Public Entrepreneurship with Democracy, *Public Administration Review*, Vol. 53, No. 4, pp. 393-395.
- (1995), *Leadership of Public Bureaucracies: The Administrator as Conservator* (Sage, Thousand Oaks, CA).
- (1998), Administrative Leadership, Neo-Managerialism, and the Public Management Movement, *Public Administration Review*, Vol. 58, No. 3, pp. 194-200.
- Thompson, F. (1997), Defining the New Public Management, *Advances in International Comparative Management*, Vol. 3, Supplement, pp. 1-14.
- Tinker, T. (1985), *Paper Prophets: A Social Critique of Accounting* (Praeger Publishers Co., New York).
- Tomkins, C. and R. Groves (1983), The Everyday Accountant and Researching His Reality, *Accounting, Organizations and Society*, Vol. 8, No. 4, pp. 361-374.
- Torres, L. and V. Pina (2002), Changes in Public Service Delivery, *Public Money & Management*, Vol. 22, No. 4, pp. 41-48.

- Truman, H.E.J. (1990), *Budgeting for Effective Hospital Resource Management* (American Hospital Publishing Inc., Washington).
- Tutty, M.G. (1997) *The Governance and Accountability Implications of New Organisational Structures*. Paper presented at the Institute of Public Administration National Conference, Dublin.
- Tyler, T.R. and R. Kramer (1996), 'Whither Trust' in R. Kramer and T. R. Tyler (eds.), *Trust in Organisations: Frontiers of Theory and Research* (Sage, London).
- Tyson, S. (1987), 'Personnel Management' in J. Gretton and A. Harrison (eds.), *Reshaping Central Government* (Transaction Books, New Brunswick, NJ.).
- Van Helden, J. (2005), Researching Public Sector Transformation: The Role of Management Accounting, *Financial Accountability & Management*, Vol. 21, No. 1, pp. 99-133.
- Van Wart, M. and E. Berman (1999), Contemporary Public Sector Productivity Values: Narrower Scope, Tougher Standards, and New Rules of the Game, *Public Productivity and Management Review*, Vol. 22, No. 3, pp. 326-347.
- Voluntary Health Insurance Board (2004), *Annual Report and Accounts 2004* (VHI, Dublin).
- Wanna, J., C. O Faircheallaigh and P. Weller (1992), *Public Sector Management in Australia* (Macmillan, Melbourne).
- Watson, D. and J. Williams (2001), *Perceptions of the Quality of Health Care in the Public and Private Sectors in Ireland: Report to the Centre for Insurance Studies Graduate Business School, U.C.D.* (ESRI, Dublin).
- Webb, E., J. (1996), 'Trust and Crisis' in R. M. Kramer and T. R. Tyler (eds.), *Trust in Organizations: Frontiers of Theory and Research*, pp. 288-301 (Sage Publications, Thousand Oaks, CA).
- Whelan, N. (1975), Reform (or Change) in the Irish Public Service 1969-1975, *Administration*, Vol. 23, No. 2, pp. 103-127.
- (1977), The Irish Public Service: Its Reform, *Administration*, Vol. 25, No. 1, pp. 1-12.
- Wilensky, H.L. (1964), The Professionalization of Everyone?, *The American Journal of Sociology*, Vol. LXX, No. 2, pp. 137-158.

- Wolfe, J.N. and M. Pickford (1980), *The Church of Scotland: An Economic Survey* (Chapman, London).
- Wolff, K.H. (1950), *The Sociology of Georg Simmel* (Free Press, New York).
- Wren, M.-A. (2003), *Unhealthy State - Anatomy of a Sick Society* (New Island, Dublin).
- (2004), *Health Spending and the Black Hole Autumn* (Economic and Social Research Institute, Dublin).
- Wright, T. (1996), 'Reinventing Democracy' in P. Hirst and S. Khilnani (eds.), *Reinventing Democracy*, pp. 7-19 (Blackwell Publishers, Oxford).
- Yeatman, A. (1994), The Reform of Public Management: An Overview, *Australian Journal of Public Administration*, Vol. 53, No. 3, pp. 287-295.
- Yin, R.K. (1994), *Case Study Research - Design and Methods* (Sage Publications, London).
- Young, L. and K. Daniel (2003), Affectual Trust in the Workplace, *International Journal of Human Resource Management*, Vol. 14, No. 1, pp. 139-155.
- Zand, D.E. (1972), Trust and Managerial Problem Solving, *Administrative Science Quarterly*, Vol. 17, No. 2, pp. 229-239.